PLAY THERAPY
WITH CHILDREN IN CRISIS

Play Therapy with Children in Crisis

Third Edition

Individual, Group,
and Family Treatment

edited by

NANCY BOYD WEBB

Foreword by Lenore C. Terr

THE GUILFORD PRESS
New York London

A Division of Guilford Publications, Inc.
72 Spring Street, New York, NY 10012
www.guilford.com

Printed in the United States of America

This book is printed on acid-free paper.

Last digit is print number: 9 8 7 6 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

Play therapy with children in crisis : individual, group, and family treatment / edited by Nancy Boyd Webb ; foreword by Lenore C. Terr. — 3rd ed.
p. ; cm.
Includes bibliographical references and index.
ISBN-13: 978-1-59385-495-9 (hardcover : alk. paper)
ISBN-10: 1-59385-495-1 (hardcover : alk. paper)
1. Play therapy—Case studies. 2. Crisis intervention (Mental health services)—Case studies. I. Webb, Nancy Boyd.
[DNLM: 1. Play Therapy—methods—Case Reports. 2. Child. 3. Crisis Intervention—Case Reports. 4. Infant. WS 350.2 P7227 2007]
RJ505.P6P56 2007
618.92′891653—dc22
2007022745

To all mental health practitioners who are committed
to helping children who have suffered stressful and traumatic life events

About the Editor

Nancy Boyd Webb, DSW, BCD, RPT-S, is a leading authority on play therapy with children who have experienced loss and traumatic bereavement. Her bestselling books, which are considered essential references for clinical courses and agencies that work with children, include *Helping Bereaved Children, Second Edition: A Handbook for Practitioners* (Guilford Press), *Mass Trauma and Violence: Helping Families and Children Cope* (Guilford Press), *Culturally Diverse Parent–Child and Family Relationships* (Columbia University Press), *Social Work Practice with Children, Second Edition* (Guilford Press), and *Working with Traumatized Youth in Child Welfare* (Guilford Press). In addition, she has published widely in professional journals and produced a video, *Techniques of Play Therapy: A Clinical Demonstration,* which won a bronze medal at the New York Film Festival's International Non-Broadcast Media Competition. Dr. Webb is the editor of The Guilford Press book series Social Work Practice with Children and Families. She is a past board member of the New York Association for Play Therapy.

A board-certified diplomate in clinical social work and a registered play therapy supervisor, Dr. Webb presents frequently at play therapy, social work, and bereavement conferences in the United States and abroad. She has been a professor on the faculty of the Fordham University Graduate School of Social Service since 1979, and in October 1997 was named University Distinguished Professor of Social Work. In 1985, she founded Fordham's Post-Master's Certificate Program in Child and Adolescent Therapy to meet the need in the New York metropolitan area for training in play therapy. In April 2000, Dr. Webb appeared as a panelist in a satellite teleconference *Living with Grief: Children, Adolescents, and Loss,* sponsored by the Hospice Foundation of America. Hosted by Cokie Roberts, the conference was beamed to more than 2,100 sites.

Dr. Webb was appointed to the endowed James R. Dumpson Chair in Child Welfare Studies at Fordham in 2002, and the same year was honored as Social Work Educator of the Year by the New York State Social Work Education Association. In 2004, Dr. Webb was named Distinguished Scholar by the National Academies of Practice in Social Work, and the same year was presented with the Clinical Practice Award of the Association for Death Education and Counseling. In 2005, she received the Sue Katz Humanitarian Award, presented by the East End (New York) Hospice, for her writing and clinical practice with bereaved children.

In addition to teaching, writing, and consulting, Dr. Webb maintains a clinical practice and supervises and consults with schools and agencies. She lectures and conducts workshops throughout the United States, Canada, Australia, Europe, Hong Kong, and Taiwan on play therapy, trauma, and bereavement.

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Foreword

Play, an activity done "just for the fun of it," serves crucial functions for the young. It encourages creativity, imagination, and general intelligence. It enables children to practice new, more advanced behaviors. It teaches them to anticipate the future. At the same time, play allows for the discharge of a child's emotions. It also facilitates the miniaturization of large problems, giving a youngster an overview of otherwise difficult-to-envision circumstances. Play helps young people to get along with others. In fact, all normal children, living in reasonably normal environments, play.

Under extreme stresses, however, young people turn their play efforts to very specific purposes. They use their play to try to master their fear-provoking pasts and anticipated futures. Using the tricks of imagination that have been "fun" up to now, stressed children (and adolescents) create monotonously grim scenes and characters, which are often repeated. The play continues regardless of any obstacles. Children in war zones, for instance, will play "war" in the street, if that is the only option for a "playground." Their need to master trauma and stress outweighs all else.

Children's overwhelming need to play out crisis or trauma suits our purposes as mental health professionals. It is our job to help such children. A traumatized or chronically stressed child's need to play with his or her dilemma is so great that the youngster will even play it out with us! Secret as the game may be, the child may also play it out in the presence of a family member. The young person may even go so far as to let us alter the presupposed set-up or outcome of the play; say something pungent about it; or say something that carries special meaning for the child.

With the options given to us by the pressing childhood need to master overwhelming situations through play, a tremendous number and variety of therapeutic interventions have become possible. In this third edition of Nancy Boyd Webb's *Play Therapy with Children in Crisis*, we find a number of completely new variations on this particular theme. Not only does the book inform us about case assessment and the uses of the various schools of therapeutic thought, but it almost puts us right into the minds of experienced treaters of children. What does a good therapist see? What does he or she think? What is said? What toy is manipulated? What is left unsaid, unmanipulated? The therapist tells us.

As I read through this exciting and oh-so-current third edition (including material related to the Iraq war and the aftermath of 9/11), I lined it up with Dr. Webb's first and second editions. Each book represents a separate and distinct journey through the world of stressed children's play. Altogether, this work is becoming an encyclopedia. It tells us why, when, and how play therapy is performed. Do not discard your old editions! In fact, try to pick up the earlier ones any way you can. And use this new third edition for your own education, review, and reassurance about what you are doing in your work with children.

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Preface

Since the publication of the second edition of this book, the world has experienced many horrendous crises and children have been exposed to a range of very stressful and frightening events. Books related to trauma have proliferated, as have professional conferences and training workshops for practitioners dealing with this topic. The numerous high-profile crises during the past 7 years include the terrorist attacks of September 11, 2001; the tsunami in Southeast Asia in December 2004; Hurricane Katrina in August 2005; and the ongoing wars in Afghanistan and Iraq. Earlier well-publicized acts of violence, also characterized by numerous deaths and destruction, include the Oklahoma City bombing in 1995 and the shootings at Columbine in 1999. Many of the survivors and the family members of victims of these terrible events have struggled with their reactions of traumatic grief, anxiety disorders, and posttraumatic stress disorder. The mental health field now recognizes that traumatic events can occur to anyone, at any place, at any time, and that the resulting anxiety often requires specialized intervention for both adults and children.

In addition to crises that receive a lot of public attention because they result in numerous deaths and wide-scale destruction, there are other types of intensely stressful occurrences that can affect children in their home life and at school. These include, for example, the deaths of parents and teachers, parental divorce, chronic sexual and physical abuse, and foster home placement. While these latter types of crises may not receive the same media attention as that following a terrorist attack, they nonetheless can cause tremendous anxiety for children in such situations.

This book presents a variety of methods to help practitioners more effectively treat children and their families dealing with anxiety resulting from crisis and trauma. The approaches to therapy presented here include group, family, and individual play interventions in the different settings in which children carry out their lives. Involvement of the parent or caretaker in the child's treatment has proven to have a positive impact on the child's ability to resolve his or her anxiety. Therefore, many chapters include parent counseling, parent therapy, or conjoint parent–child therapy as an essential component of the child's treatment.

Eight chapters are devoted to helping children with difficulties related to family-based problems, four chapters discuss helping children in school, and five chapters deal with crises in the community and the world. Of the 21 chapters in this edition, 17 are completely new. The remaining four have been thoroughly revised with new references. One chapter (Chapter 10) includes a longitudinal update regarding a child whose treatment was presented in the second edition and who now is an adult cancer survivor. Another (Chapter 21) focuses on helping practitioners avoid secondary traumatization. The Appendix provides much useful information about play therapy resources, training programs, and professional organizations and journals dealing with trauma and crisis to aid practitioners who wish to pursue their work in this field.

During the last decade empirically based research has brought much attention to cognitive-behavioral interventions as the treatment of choice in work with sexually abused children. One chapter in the book (Chapter 6) describes this method. In addition, the approaches to treating traumatic grief presented in this volume will likely complement those currently being applied by cognitive therapists. The book also includes chapters based on "anecdotal" evidence and practice wisdom and experience about helping approaches the authors have found to be effective with various types of problems. In-depth case examples provide the reader with the opportunity to accompany the therapy close at hand.

The traumatic events of the past decade have required adaptations to where and how soon therapy is conducted, particularly when treating children in the aftermath of natural disasters. Often the reality of the situation requires that play therapists go to the scene of the disaster itself to work with children individually and/or with family members or school groups. The premise of crisis intervention is that when help is offered soon after a traumatic event this "psychological first aid" may prevent the escalation of anxiety symptoms into later full-blown posttraumatic stress disorder.

The professional backgrounds of the chapter authors range across many mental health fields and include social workers, school counselors, a psychiatrist, psychologists, grief counselors, educators, and private practitioners. What they all have in common is their belief in the healing power of the therapeutic relationship and in the value of play therapy as the key to understanding the child's inner world. I am deeply grateful to the clinicians who have written so comprehensively and movingly about their work, and to the clients and families who granted them permission to do so. As I stated in the preface to the second edition of this book, we need these detailed examples of actual practice in order to learn about effective approaches to helping. It is my hope that future children and families will benefit from these contributions.

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PLAY THERAPY
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part 1

THEORETICAL OVERVIEW

Chapter 1

The Family and Community Context of Children Facing Crisis or Trauma

Nancy Boyd Webb

Crises and traumatic events are ubiquitous in modern life and affect people of all ages. Contrary to the myth that the magic years of childhood are a period of guileless innocence and carefree play, the reality of the preteen years, like that of later life, includes experiences that provoke anger, jealousy, fear, and grief as well as joy and pleasure. When children experience crises or traumas, their families and communities inevitably also are involved. Sometimes adults actually cause children to be victimized, as in cases of abuse. In other situations (such as natural disasters), no one person is responsible, and the entire affected community must deal together with the shared experience.

This revised volume begins with a focus on the family and community environment in which children live, because of the importance of this social context to the nature of children's reactions in crises or traumatic situations. We know that children depend on the adults around them for security and protection, and the younger they are, the more this is the case. Furthermore, evidence in the professional literature increasingly attests to the influence of adults' responses to crises or traumas on the subsequent nature of children's reactions (Arroyo & Eth, 1996; McFarlane, 1987; Rustemi & Karanei, 1996; Pfefferbaum, 1997; Swenson et al., 1996). Because children watch and take their cues from adults, when their caretakers feel and act terrified, children become even more panicked—since they know that they themselves are helpless and powerless.

This book recognizes and discusses the vast range of stressful events that may impair everyday functioning and cause emotional pain to young children. The specifics of the *individual* child's response and the challenge of making a differential diagnosis are presented in the second chapter. The present chapter discusses the role of family and community contextual factors in a child's surrounding social environment that have the potential to ameliorate or worsen the child's response to a crisis or trauma. The nature of the crisis or traumatic event is also considered, since this can have various effects on the type of contextual support the child receives. I have previously diagrammed the three groups of interacting factors affecting a child's responses to crisis or trauma and have labeled the process of assessing these factors "tripartite assessment" (Webb, 1993, 1999, 2004a, 2006). Figure 1.1. shows the latest adaptation of this conceptualization.

The next section presents an overview of the concepts of "stress," "crisis," and "trauma" as preliminary to examining the role of environmental risk and protective elements in buffering or escalating a child's response to a crisis or traumatic event.

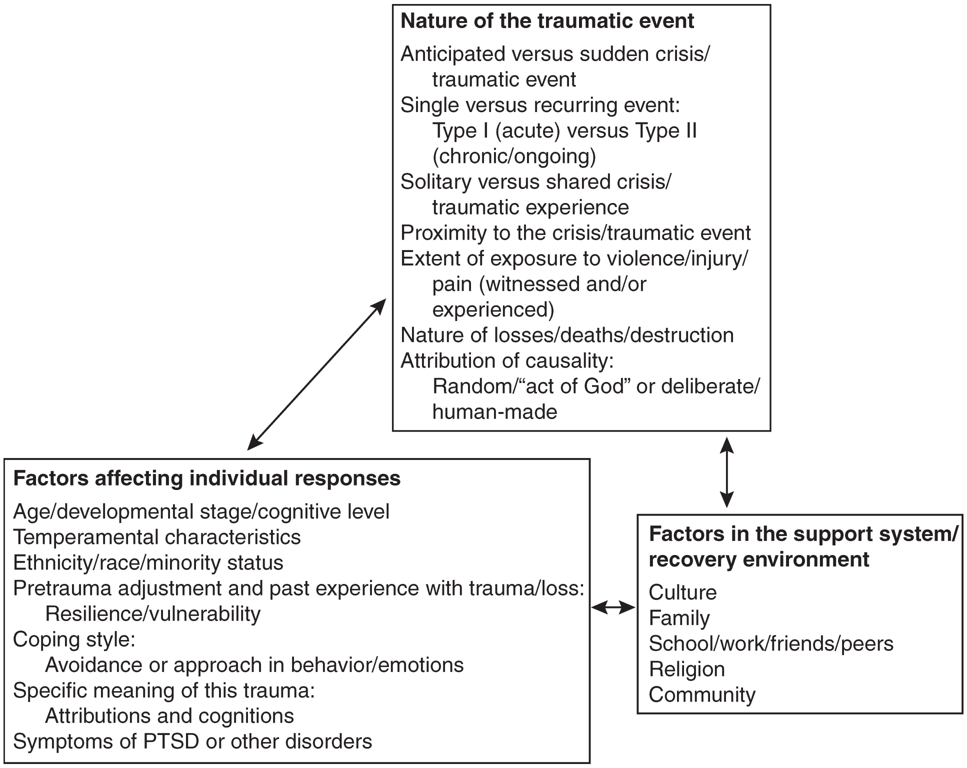

FIGURE 1.1. Interactive components of the tripartite assessment of a child's responses to a crisis/traumatic event. Adapted from Webb (2004a). Copyright 2004 by The Guilford Press. Adapted by permission.

STRESS, CRISIS, AND TRAUMA

The conditions of stress, crisis, and trauma involve distinct but overlapping concepts. Whereas the "average" person (adult or child) carries out his or her life with the ability to withstand most of the ups and downs of a typical day, some people are less resilient to stress because of their temperaments or because their personal histories make them vulnerable. For example, an 11-year-old girl may wake up 20 minutes late and have to skip breakfast to avoid being late for school. The child in this situation feels some stress, but her stress level soon diminishes once she decides to omit her breakfast and to drink or eat something on the way to school, thereby allowing her to arrive on time. In contrast, another girl in a similar situation may not see any alternative to being late; she becomes hysterical and decides not to go to school at all, because she is afraid of being reprimanded for being late. Furthermore, she fears that the school will report her absence to her mother, who will respond punitively. If we speculate that this second girl has a history of being harshly abused by her mother, we can see that the same circumstance—waking late—creates stress for both girls, but precipitates a crisis for the second girl, who may already be functioning on a marginal level because of her history of traumatic abuse. Figure 1.2 depicts the interaction and progression among the concepts of stress, crisis, and trauma.

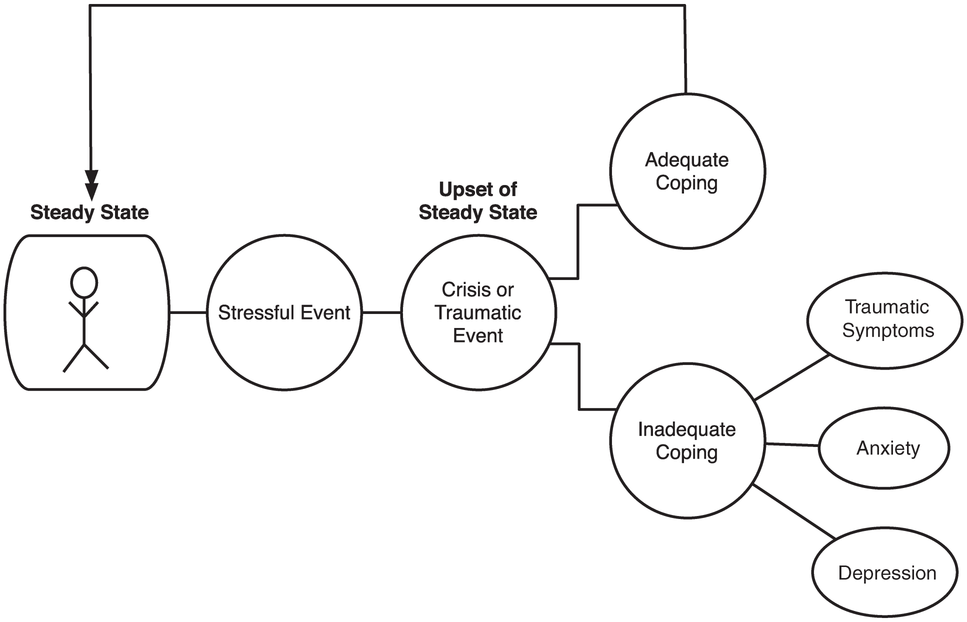

FIGURE 1.2. The interaction of stress, crisis, and trauma.

Stress

Everyone knows how it feels to be under stress. These feelings typically emerge in situations that an individual perceives as challenging or threatening. Usual responses to stress involve either attempting to get away from the uncomfortable circumstances (flight) or, alternatively, aggressively confronting the cause of the problem (fight). This dynamic has been called the "fight-or-flight" response (Selye, 1978).

The body under stressful circumstances actually undergoes physiological changes due to the outpouring of steroid hormones from the adrenal glands, causing increased heart rate, breathing rate, blood pressure, metabolic rate, and blood flow to the muscles (Benson, 2000; Selye, 1978). Although Selye maintained that stress in itself is not harmful, he pointed out that it may precipitate a state of crisis if the anxiety that accompanies it exceeds the individual's ability to function adequately.

People have different levels of stress tolerance, as well as different ways of responding to stress. Young children are particularly vulnerable to stress because of their youth, immature defenses, and lack of life experience. They often require assistance from adults to obtain relief from their anxiety and to learn new coping methods.

Crisis

The term "crisis" refers to a situation that appears to exceed an individual's coping ability, and results in malfunctioning of emotions, cognition, and behavior (James & Gilliland, 2004). The person perceives and believes that the event or situation is an intolerable difficulty that exceeds his or her resources and ability to cope. This emphasis on the *perception* of the event, rather than on the event itself, appropriately draws attention to the unique underlying meaning of the situation to each individual. As demonstrated in the case of the two girls who wake late for school, different people experience the same situation differently, and idiosyncratic factors determine their separate perceptions of the crisis.

Another example of distinctive responses to the same stressful situation involved a group of third-grade children, following the news of the sudden death of one of their classmates in an automobile accident. All the children in the victim's class displayed some degree of shock, concern, and curiosity about the death, but individual reactions varied greatly. One child told his teacher the next day (falsely) that his father had died suddenly the previous evening. Another child complained of headaches and stomachaches for a week with no physical cause, and a third child, who was a close friend of the dead child, had frightening nightmares for several weeks about being chased by a monster. However, most of the children in the class did not develop symptoms and did not appear to be traumatized by the death (in the opinions of the teachers and the school social worker), although the child with the nightmares did benefit from six play therapy sessions. See Webb (2002) for a full discussion of this case.

Anna Freud (1965, p. 139) states that "traumatic events should not be taken at their face value, but should be translated into their specific meaning for the given child." I believe that the same is true of crisis events more generally. This point is elaborated by Green, Wilson, and Lindy (1985, p. 59), who maintain that "different people who are present at the same event will have different outcomes because, not only will their experiences differ, but the individual characteristics they bring to bear upon the psychological processing are different, and *this processing may take place in differing recovery environments*" (emphasis added). For a child in crisis, the "recovery environment" holds particular significance because of the child's dependence on family members and other adults to provide support and guidance. Thus the tripartite assessment of the child in crisis includes an analysis of (1) individual factors interacting with (2) the resources of the family and the social support network, in the face of (3) a particular crisis situation.

An underlying principle of crisis intervention theory is that crises can and do happen to everyone (James & Gilliland, 2004; Parad & Parad, 1990; Webb, 1999). No previous pathology should be assumed when, for example, a child becomes withdrawn and apathetic after her mother is hospitalized for surgery. Although individual differences influence personal vulnerability to breakdown and the form and timing of the disturbance, no one is immune from the possibility of becoming overwhelmed in the aftermath of a crisis.

Therefore, the phrase "stress overload" seems very relevant to crisis situations, and it explains the progression from stress to a state of crisis, as depicted in Figure 1.2. The overload causes the individual to feel disorganized, confused, and panicked. When these feelings continue without relief, anxiety, depression, and/or at least some symptoms of posttraumatic stress disorder (PTSD) may develop. In fact, some theorists believe that "the degree of distress caused by an event is the major factor determining the probability of the onset of psychiatric disorder" (McFarlane, 1990, p. 70). Therefore, a crisis intervention approach that aims to lessen the anxiety of the people involved in a crisis and to bolster their coping strategies is purported to be useful for the primary prevention of psychiatric disorders. As we will see in many cases presented in this book, crisis intervention services are frequently short-term, because most crises by their very nature are time-limited. "A minimum of therapeutic intervention during the brief crisis period can often produce a maximum therapeutic effect through the use of supportive social resources and focused treatment techniques" (Parad & Parad, 1990, p. 9).

Trauma

In contrast to the possibility of brief and successful treatment of anxious individuals following crisis events, therapy for *traumatized* persons often takes considerably longer. The word "trauma" comes from the Greek, meaning "wound." In the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), the American Psychiatric Association (2000, p. 467) defines exposure to trauma as experiencing, witnessing, or being confronted with "an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others," and as responding with "intense fear, helplessness, or horror." Situations that may prove to be traumatic include experiences of physical or sexual abuse; the witnessing of violence in the family or community; natural or human-made disasters involving extensive destruction of property, injury, and mutilating deaths; and the experiences of war or terrorism. As mentioned previously, children often become terrified through witnessing adults in states of panic, high arousal, or frozen shock during traumatic events. The challenge of assessing a child who has been exposed to a crisis or a traumatic event will be discussed in the next chapter.

THE NATURE OF THE CRISIS OR TRAUMATIC EVENT AND ITS IMPACT ON CONTEXTUAL SUPPORT

Seven components are enumerated in the tripartite assessment as influencing the nature of a crisis or traumatic situation. The present discussion focuses on how these factors may affect not only the individual, but also the type of support (or lack thereof) provided by the family and social environment. The specific components that influence the crisis/traumatic event include the following:

- Anticipated versus sudden crisis/traumatic event
- Single versus recurring event: Type I (acute) versus Type II (chronic/ongoing)
- Solitary versus shared crisis/traumatic experience
- Proximity to the crisis/traumatic event
- Extent of exposure to violence/injury/pain (witnessed and/or experienced)
- Nature of losses/deaths/destruction
- Attribution of causality: Random/"act of God" or deliberate/human-made

Anticipated versus Sudden Crisis/Traumatic Event

The Scout motto, "Be prepared," implies by contrast the undesirability of being caught off guard. Some events that lead to crises or traumas are by their nature unpredictable. Examples include natural disasters with no preliminary warning, the sudden death of a parent who was previously well, and the killing and injury of innocent bystanders in a wanton shooting episode. These contrast with other situations that gradually build up to a crisis or trauma. Examples of anticipated crises include a family's move to another community, the departure of the father from the home as the beginning of a marital separation, and the terminal illness of a family member. Stressful events that develop toward predictable outcomes present the opportunity for gradual comprehension and assimilation of the impending transition or loss.

However, many well-meaning adults deliberately try to shield children from worry, and they avoid exposing them until the last minute to situations they believe will prove upsetting. For instance, they do not talk about a father's impending overseas military deployment until the day of his departure. This prevents children from "getting ready" psychologically, asking questions, and bracing themselves for the upcoming stressful loss. Often adults do not know how to talk with children about future stressful matters, especially when they themselves are afraid and anxious.

A substantial body of children's literature exists to assist adults who want to help children deal with stressful life events through the medium of stories (Fassler, 1987; see also various books published by the Magination Press, a division of American Psychological Association Publications). Books are available that focus on distressing events and circumstances of all kinds, such as a grandparent's death, the terminal illness of a parent, parental divorce and remarriage, and foster placement and adoption. The crisis techniques of "role rehearsal" and "anticipatory guidance" (Parad & Parad, 1990) attempt to help individuals prepare in advance for future difficult situations. For example, a child who has advance knowledge, through pictures and explanations, about surgical masks and medical procedures shows less anxiety when confronted with these in a hospital. This "mastery in advance" through reflection or fantasy provides a form of "psychological immunization," leading to enhanced coping in future stressful situations (Kliman, 1968). A folk saying claims that "a job well dreaded is more than half done." Even though the dreading is unpleasant, it permits anticipatory problem solving and psychological preparation. Parents, teachers, and community persons who have contact with children should be encouraged not to shield them, but to help prepare children for possible future stressful life experiences, and to assist them in talking about and dealing with their current worries as well.

Single versus Recurring Events: Type I versus Type II

The notion of the "straw that breaks the camel's back" suggests that accumulated stress may weigh so heavily that not even one minor additional stress can be tolerated. Thus the precipitating factor in a crisis may not be as significant as the events that have preceded it and created a "vulnerable state" for the individual (Golan, 1978). In the earlier example of the child who has suffered repeated physical abuse, a relatively minor occurrence such as a reprimand from a teacher could precipitate a crisis because of the child's preexisting vulnerable state.

Terr (1991) has proposed the concepts of "Type I" trauma, which occurs following *one* sudden shock, and of "Type II" trauma, which is "precipitated by a *series* of external blows" (p. 19; emphasis added). Responses to Type I traumas may include detailed memories and misperceptions, whereas reactions to Type II traumas often involve denial, numbing, dissociation, and rage. Sometimes the two types of traumas coexist. When untreated, either type can lead to serious disorders in both children and adults, but this is particularly true of Type II. For example, common sense suggests that the witnessing of a teacher's murder may have very different repercussions for a child whose development is proceeding normally and whose parents offer appropriate comfort and support, as compared with a child who lives in a dangerous neighborhood where guns and violence are commonplace and whose older siblings talk about needing a gun for self-protection. In most circumstances, Type I traumas do not lead to long-term symptoms, and recovery occurs in more than three-quarters of cases, even after very tragic experiences (McFarlane, 1990; Cohen, 2004). Type II traumas, however, may require long-term treatment.

Solitary versus Shared Crisis/Traumatic Experience

If "misery loves company," then we would expect the sharing of a crisis or traumatic experience to offer a degree of comfort and support that is absent when an individual undergoes such a stressful crisis alone. Certainly the dynamic of guilt ("What did *I* do that caused this?") and issues of personal responsibility ("What *should* I have done?") are irrelevant or greatly reduced in shared situations. Although every crisis or traumatic event is experienced ultimately on a personal level, the knowledge that others are enduring similar turmoil may reduce the stigma of victimization. For example, a child victim of incest may gain extraordinary benefits from participation in a support group of similarly victimized children.

However, the commonality of a shared crisis or traumatic event does not automatically lead to bonding among the individuals involved. Terr (1979), reporting on the aftermath of the kidnapping of a school bus of summer school students, found that the traumatized youngsters avoided contact with one another after the horrible experience was over. As if to escape the memories of their ordeal, these children tried to blend into the community and to stay away from the students who had shared the trauma and who reminded them of the frightening experience. This type of avoidance was also noted by many group therapists who unsuccessfully attempted to convene bereavement support groups soon after the New York World Trade Center terrorist attacks of September 11, 2001 (Hartley, 2004).

Age is a crucial factor in determining the extent to which the sharing of a crisis or traumatic situation helps children, since the influence of peers is not strong until the middle years of elementary school. Preschool children rely on their familiar adult caretakers, rather than on peers, to provide them comfort and security when they are upset. Unfortunately, parents and teachers often minimize children's anxious responses (La Greca & Prinstein, 2002), thereby increasing the likelihood that children in distress will not receive timely treatment.

Proximity to the Crisis/Traumatic Event

A research study in California following a sniper attack in a school playground (Pynoos & Nader, 1989) found that children who were in closer physical proximity to the shooting developed more symptoms of PTSD than children who were on the periphery or not on the playground when the attack occurred. Proximity to the shooting resulted in more severe responses, both soon after the event and 14 months later (Nader, Pynoos, Fairbanks, & Frederick, 1990). These findings, which seem intuitively valid, confirm that proximity to a crisis or traumatic event results in intense sensory responses together with a heightened sense of life threat, all of which can contribute to symptom formation.

However, as I have written previously (Webb, 2004b, p. 8), "proximity can be viewed as emotional, as well as geographic." Many employees who worked in the New York World Trade Center lived some distance from ground zero. Their families who watched the disastrous events of 9/11 on television clearly were in close "emotional proximity" to the traumatic events. In fact, in this age of high media exposure, even very young children may watch horrific events such as the World Trade Center's destruction, and see clouds of smoke and people jumping from buildings to escape. Research after both the Oklahoma City bombing of 1995 and the 9/11 attacks showed an association between televised coverage of the terrorist events and children's adverse psychological outcomes (Pfefferbaum et al., 2004). These exposure experiences may qualify as "vicarious traumatization" (McCann & Pearlman, 1990), since they involve auditory and visual scenes of horror. Unfortunately, many families did not protect their children from watching repeated media replays of these traumatic events, and some children became very confused and troubled by seeing them. In these instances, "proximity to the event" occurred within their own living rooms.

Extent of Exposure to Violence/Injury/Pain (Witnessed and/or Experienced)

As the preceding discussion suggests, we live in a violent world that does not shield children from graphic exposure to conflict in all forms and locales, including the family, school, and community. American society seems to have a high baseline tolerance for violence, which within the family takes the form of child abuse, spouse or partner abuse, incest, and other assault episodes. Pynoos and Eth (1985, p. 19) believe that "children who witness extreme acts of violence represent a population at significant risk of developing anxiety, depressive, phobic, conduct, and posttraumatic stress disorders." (This risk, of course, is even higher when children are themselves the victims of such violent acts.) Indeed, the presence of severe threat to human life in which the individual's response involves intense fear, helplessness, and horror constitutes the precondition for a traumatic experience in the DSM-IV-TR diagnosis of PTSD, as I have noted earlier and as will be discussed in the next chapter.

Child witnesses typically experience a sense of helplessness and confusion when confronted with human-induced acts of violence. Especially when these traumatic events occur in their own families, children become flooded with feelings of anger, vulnerability, and fear, because they realize that the very people who are supposed to love and protect them are instead deliberately hurting them or other family members. This usually interferes with the development of a secure attachment relationship (Davies, 2004).

When violence results in death—as, for example, in a school shooting—the community and newspapers may sensationalize the event, and the people involved may feel overwhelmed by an emotional battery of reactions, including shame, hatred, and guilt. A family can help a child by ensuring safety and protection despite these upsetting circumstances. However, sometimes the family members choose to close ranks and create a barrier of silence around the traumatic event (Eth & Pynoos, 1985, p. 177). This leaves the child with no outlet for discussion and questions, nor any way to process his or her emotions. Fortunately, schools have become more attuned to the wisdom of providing some form of psychological debriefing or first aid to students following a school-based crisis or trauma. Part III of this book presents several examples of helpful school interventions.

Nature of Losses/Deaths/Destruction

Losses play a major role in many crises and traumatic situations, and the associated reactions of confusion, anger, and desperation may be understood as mourning responses associated with the losses. When the losses include death of or separation from family members, grief and mourning are appropriate responses. Less obvious losses occur in situations such as moving or school promotion, which require giving up a familiar location or status and developing new relationships. Teachers can attest to the high level of anxiety in September until children become comfortable with the expectations and people in their new grade. This anxiety usually does not cause a state of crisis for most children, but it can put them into a vulnerable state in which their ability to cope is reduced temporarily.

The converse of loss is attachment. If no positive bonding existed, no mourning would be necessary. Bowlby's (1969) seminal work on attachment highlighted the biological source of the need for proximity in human relationships, with the prototype of attachment being the mother–infant relationship. Although object constancy permits the mental retention of loved persons in the memory, nonetheless a child whose parents separate and/or divorce is deprived of daily contact with one of his or her attachment figures, and thus suffers the loss both of this person and that of the intact nuclear family. Other losses following divorce often include a change of residence, school, and lifestyle. But it is the loss of contact with an attachment object (the nonresident parent) that results in the most serious deprivation for children. Multiple losses cause multiple stressors, adding to the potential for crisis.

Illness, although a common occurrence for children, introduces a number of temporary or permanent restrictions on a child's life, which the child experiences as losses. The child with a terminal illness, for example, must adapt to bodily changes, environmental restrictions, changed expectations for the future, and changed relationships based on others' altered perceptions of him or her. These all constitute losses (which also prevail to a much lesser degree for the child who remains home from school for a week with chickenpox). Physical injury or pain constitutes a serious threat to the child's basic sense of body integrity, compounding the other stresses associated with medical treatment. The family has an important role in helping the child cope with a serious medical crisis. (See Goodman, Chapter 10, this volume, for further discussion.)

Losses constitute a significant component of a crisis or traumatic event. Both losses that are "vague," such as the loss of a sense of predictability about the environment (e.g., following a tsunami or terrorist attack), and more evident losses, such as the death of a pet, can create stress and anxiety. In addition, memories of past experiences of loss and bereavement often become reawakened in current loss situations, thereby complicating the individual's responses.

Attribution of Causality: Random/"Act of God" or Deliberate/Human-Made

Children often seek to attach blame after something "bad" happens. For example, because preschool children are naturally egocentric, such a child may believe that something he or she did or did not do caused a parent's death. As children grow, their understanding becomes more mature and sometimes reveals their search for logical reasons for tragic events. This was illustrated by an 8-year-old boy who asked in disbelief following the 9/11 attacks, "Why did they do it, when *we* taught them to fly?" (Webb, 2004b, p. 10). The child's black-and-white sense of right and wrong was shattered, and this may have led to erosion of this boy's faith in human nature. An older child usually has more understanding about the complexity of human behavior and motivation, including the reality of deliberate malevolent actions. This awareness may lead to disillusionment about other people and increased anxiety about the safety of the world.

Of course, sensitive caregivers can buffer children's anxiety by reassuring them that the current experience is not typical of *all* people, and that goodness exceeds evil in the world. For example, although many children were confused and worried about the United States going to war in Iraq, some communities projected a sense of patriotism, national security, and strength that was reassuring to many families and children.

As compared with a terrorist or other human-made act, when a crisis/traumatic event occurs as the result of a seemingly random occurrence or "act of God," the element of blame is often less intense. Many adults respond with a kind of fatalistic attitude that there is nothing anyone could have done to prevent this type of crisis. This acceptance makes the resulting grief less complicated. However, blaming still may occur with regard to the management of disaster relief efforts. For example, in the aftermath of Hurricane Katrina, many people complained about inadequate government intervention to alleviate their suffering, and hundreds (or thousands) of children were subjected to both physical and emotional pain as a result of the massive dislocation and destruction they witnessed and experienced after the disaster.

CONTEXTUAL ELEMENTS THAT HELP OR HINDER CHILDREN IN CRISIS/TRAUMATIC SITUATIONS

A crisis happens to a specific individual within the context of his or her social and physical environment. We now consider some of the features of this contextual surround that may either help or hinder the child in crisis. The nature of the support system is particularly important for children in crisis/traumatic situations, because their youth and dependence make them especially reliant on others to assist them (Pfefferbaum et al., 2004).

Culture and Religion

The term "culture" encompasses the beliefs, values, morals, customs, and world views that are held in common by a group and to which its members are expected to conform (Webb, 2001). Cultural values pervade all aspects of life and are often shaped by specific religious practices and beliefs. For example, the responses of many Buddhists following the December 2004 tsunami in the Far East reflected their fatalistic belief in *karma*, with the acceptance of such events as part of the cycle of life. In striking contrast, many fundamentalist Christians in south Florida following Hurricane Hugo attributed the storm to God's intent to "teach them a lesson." These different perceptions demonstrate how culture and religion constitute the lens through which people view their worlds.

Whereas all people experience stress, their culture determines whether and in what manner they acknowledge this distress. For example, Fang and Chen (2004) reported the case of Chinese parents living in New York following the 9/11 World Trade Center bombing who were unable to understand their daughter's traumatic nightmares and school failure as part of the girl's anxiety reaction. They did not want her to consult the school psychologist about her poor grades and difficulty concentrating because the parents considered that this would reveal the girl's "weakness" and therefore "shame" the family. Psychological problems are considered disgraceful in some cultures, and the challenge for counselors and therapists is to find a way to frame these difficulties in terms of "normal" responses in difficult situations (Nader, Dubrow, & Stamm, 1999). The cultural and religious backgrounds of different groups influence the way a crisis or traumatic event is perceived and the nature of the response (McGoldrick, 1982; McGoldrick, Giordano, & Garcia-Preto, 2005). McGoldrick (1982, p. 6) states categorically that "the language and customs of a culture will influence whether or not a symptom is labeled a problem . . . [and that] problems can be neither diagnosed nor treated without understanding the frame of reference of the person seeking help as well as that of the helper."

Thus it is imperative for a therapist to identify and weigh the significance of cultural and religious factors in trying to understand the family's reaction to a crisis or traumatic situation. In the previous example, had the school social worker telephoned the Chinese parents and suggested that they seek a mental health evaluation for their daughter, the parents would have felt disgraced and angry, and they probably would have declined the suggestion and blamed their girl for speaking about her problem to outsiders. However, had the social worker stated that she was sending *all* parents some information about the typical reactions of children and youth after disasters, and then pointed out that it was important to help children so that their schoolwork did not suffer, the chances of parental cooperation would have been far greater.

Nuclear and Extended Family

Most people seek out their close family members at times of crisis, either directly or via telephone. Proximity seeking is a hallmark of attachment. Children are no exception, and in stressful situations they cry for their mothers (or other primary caregivers) and cling to them for comfort. The nature of the mothers' responses, in turn, has a strong influence on how the children will react—even during the stresses of wartime. Freud and Burlingham (1943) reported that children who remained with their mothers in London during the Blitz of Wold War II fared better than those who were evacuated to the country, where they lived more safely but with strangers. When parents can remain calm, their children tend to follow suit. However, this places a great burden on parents who themselves may be traumatized (Benedek, 1985). Even in a noncrisis situation, "financial constraints, absorption in professional development, moves, or deaths of significant relatives can significantly encroach on [an] adult's available energy to parent effectively" (Chethik, 1989, p. 33).

A genogram is the starting point for identifying all family members who potentially can provide support to a child in crisis. In the process of creating a three-generation genogram with the family, the crisis therapist learns not only the names of family members, but also their geographic location, their frequency of contact with one another, and something about the quality of their various relationships. It is helpful to ask in completing the genogram, "Of all these various family members, which ones do you consider most important to the child?" The response sometimes reveals the influence of an aunt or uncle in the child's life, which might not otherwise be known.

The family members' demographic characteristics (e.g., age, socioeconomic status, level of education), in addition to their cultural characteristics, often affect the particular way they respond to a crisis or trauma. In particular, we must recognize that children growing up in impoverished families frequently lack supportive resources. Parents living in poverty often experience more financial stress and suffer more depression and psychological distress than do more affluent parents (Huston, 1995). Therefore, parental support may be absent for those children who most need adult protection, due to dangerous inner-city neighborhoods with very high levels of interpersonal violence (Fick, Osofsky, & Lewis, 1994). The ideal of a safe, nurturing, supportive environment is far from the reality of many children in poverty.

School, Friends, and Community Supports

The "eco-map" (Hartman, 1978) provides a diagrammatic tool for illustrating the available types of support surrounding a family or household (see Figure 1.3). This is an excellent means of analyzing potential resources in a child's network of friends, church, school, health care, and other institutions. The Beatles sang about getting by "with a little help from my friends," and that continues to be true for those fortunate enough to have caring friends who can help. Benedek (1985) stresses the importance of significant, caring human relationships in situations where the child and parents have experienced a crisis or trauma together. It is not surprising that more supportive environments tend to be associated with a better adjustment to stressful situations.

Beyond the family circle, the school can serve as either a refuge or a source of dread for a child, depending on the degree to which he or she feels comfortable in the peer environment. School-age children typically seek out friends who are similar to themselves. This friendship group broadens a young person's sphere of contacts outside the family, and sometimes provides an important source of support at times when the child's own family may be caught up in their own conflicts, such as separation and divorce (Davies, 2004). On the other hand, a child who does not fit in at school may suffer the effects of negative peer contacts, which can cause the child to dread going to school for fear of ostracism or bullying. The newspapers have reported the disastrous outcomes of such bullying when "rage-full" victimized youth erupt in a shooting rampage. Chapter 12 in this book deals with this situation more fully.

Community problems can affect children to varying degrees, depending on their scope and meaning to the child. For example, a youngster living in a rundown tenement building surrounded by gang warfare will probably react more strongly if he or she witnesses a shooting than will a child the same age who lives in a safe neighborhood. The first child realizes (probably not for the first time) that his or her neighborhood is not safe, and therefore he or she may experience an increased sense of vulnerability. Children in this situation may benefit greatly from community programs in which they can participate in sports, recreation, or church activities under the careful supervision of coaches, teachers, or religious leaders, who serve as both protectors and positive role models. Unfortunately, however, all too frequently communities in poor neighborhoods lack the kind of after-school activities that could assist underprivileged youth to grow up with positive views about themselves and their world.

CONCLUDING COMMENTS

The term "resilient" has been used to describe children who demonstrate successful adaptation despite high-risk status, chronic stress, or prolonged or severe trauma (Egeland, Carlson, & Stroufe, 1993; Garmezy, 1993; Masten, Best, & Garmezy, 1990). "Resilience" is defined as "the ability to recover readily from

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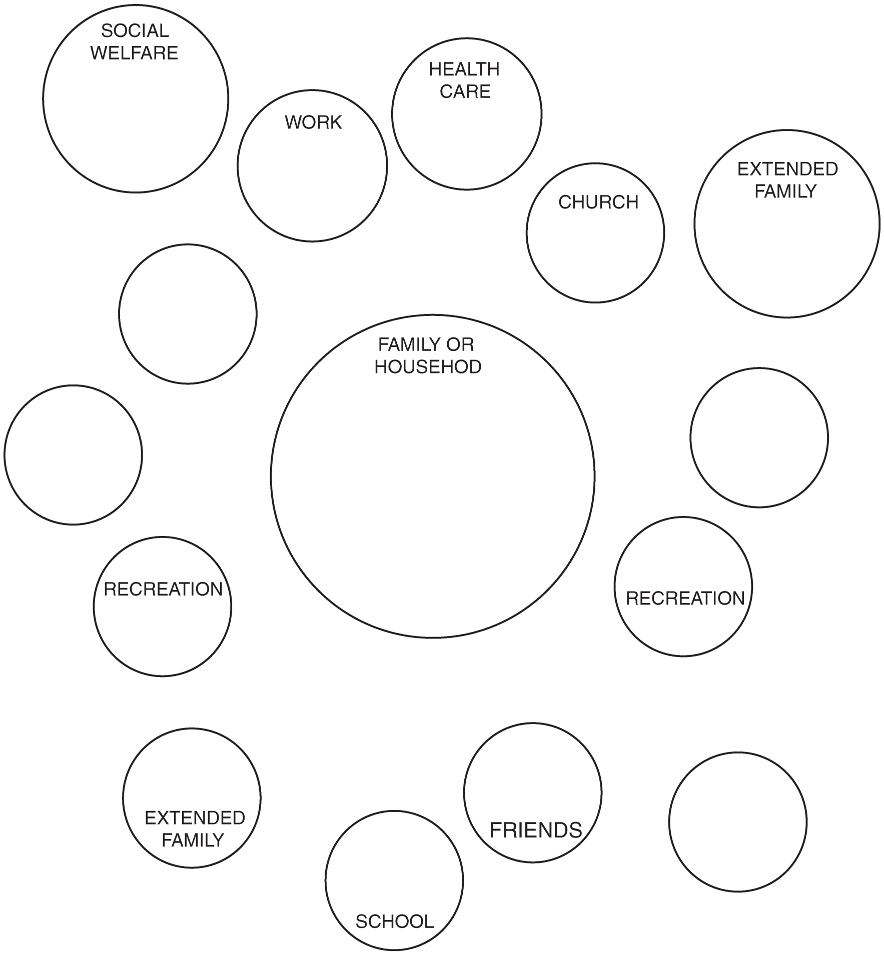

Fill in connections where they exist.
Indicate nature of connections with a descriptive word or by drawing different kinds of lines:
——— for strong, - - - - - - - for tenuous, ++++++ for stressful.
Draw arrows along lines to signify flow of energy, resources, etc. → → →
Identify significant people and fill in empty circles as needed.

FIGURE 1.3. Eco-map. From Hartman (1978). Copyright 1978 by Family Association of America. Reprinted by permission.

illness, depression, adversity, or the like" (*Webster's College Dictionary*, 1968, p. 1146). If we consider resilience to be an *internal* capacity, we must also acknowledge that this ability inevitably interacts with *external* factors, which may be either nurturing and supportive or difficult and depriving (or some combination of the two). Thus resilience is a transactional *process* that "develops over time in the context of environmental support" (Egeland et al., 1993, p. 518).

However, the existence of risk factors such as poverty, parental divorce, parental substance misuse, and/or parental mental illness by no means sentences a child to negative life outcomes, according to Rak and Patterson (1996). These authors optimistically report that protective factors, such as individual temperament and unexpected sources of support in the family and community, can buffer a child who is at high risk and help such a child succeed in life. See Davies (2004) for a full discussion of the intricacies and interrelationship among risk and protective factors in the child, the family, and the community.

Clearly, multiple factors affect each child in each situation—factors that the tripartite assessment summarizes. Consideration of the numerous elements that help or hinder a child's unique adaptation in different crisis situations constitutes the heart of understanding—and, ideally, such understanding will lead to appropriate assessment and treatment, as we will see in the following chapters.

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Chapter 2

Assessment of the Child Following Crisis

THE CHALLENGE OF DIFFERENTIAL DIAGNOSIS

Kathleen Nader

A defined set of criteria and specific symptoms for diagnosing a disorder enhance the study, understanding, and treatment of the disorder (Allnutt & Chaplow, 2000; Nader, in press). Assessment for posttraumatic stress disorder (PTSD) or acute stress disorder (ASD) is common for youth who have been exposed to traumatic events. As van der Kolk and Courtois (2005) point out, however, the diagnosis of PTSD captures only limited aspects of posttraumatic psychopathology. Youth may respond to their traumatic experiences with disorders, symptoms, and patterns of thought and behavior other than those described in the diagnostic criteria for PTSD (Nader, 2001, in press). Accurate diagnosis is important to successful interventions for both youth and adults.

For disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV; American Psychiatric Association [APA], 1994) and its text revision (DSM-IV-TR; APA, 2000), a great deal of co-occurrence and symptom overlap exist (Cohen & Mannarino, 2004; Ingram & Price, 2001; Kimerling, Prins, Westrup, & Lee, 2004; see Boxes 2.1 and 2.2, below). Most studies focus on one disorder without taking into account the frequent comorbidity of disorders and the effects of disorder combinations on the nature of response and recovery (Kessler, 2000). PTSD presents with high rates of comorbidity. Evidence suggests that treatments for simple PTSD may not be applicable to complex trauma or PTSD with comorbid disorders (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

MIXED FINDINGS IN RESEARCH ON CHILDHOOD TRAUMA

For many variables assessed in the study of childhood trauma, findings have been mixed (Nader, in press). Different experiences may result in similar reactions, and similar experiences may result in diverse outcomes (McBurnett, King, & Scarpa, 2003; Nader, in press; Yates, Egeland, & Sroufe, 2003). Multiple factors affect youth's reactions to traumatic experiences (Nader, 2004a, in press; Webb, 2004, 2006; see Webb, Chapter 1, this volume). Risk and resilience factors, such as aspects of parent–child relationships, personality traits, environmental conditions, and personal background, may influence youth's susceptibility to symptoms and influence the nature of their reactions. The varied outcomes of exposure to traumas in early life is often seen as a consequence of the transactions among such variables as temperament, attachment, coping strategies, neurobiology, and the subjective nature of traumatic experiences (Lyons-Ruth, Zeanah, & Benoit, 2003; Pasquini, Liotti, Mazzotti, Fassone, & Picardi, 2002). Reporting differences also exist among cultures and between the sexes (Nader, in press; McCrae, Terracciano, & 78 Members of the Personality Profiles of Cultures Project, 2005).

CHILDHOOD ADVERSITIES AND ADULT DISORDERS

Retrospective studies have consistently found that adults with psychiatric disorders report exposure to childhood adversities significantly more often than other adults do (Kessler, Davis, & Kendler, 1997). Such adversities often occur in clusters. Although most studies examine specific disorders such as PTSD, Kessler et al. (1997) found that the effects of particular adverse events are not confined to any one class of disorders. When studies control for lifetime comorbidities, the effects of a variety of adversities—whether or not they meet DSM-IV(-TR) Criterion A for PTSD and ASD—are distinguished more by their similarities than by their differences. After adjusting for overlap among adversities, parental psychopathology (especially maternal mental disorder) and interpersonal traumas (especially rape and kidnapping) had comparable substantive import in adult psychopathology. Kessler et al. (1997) found that adults' recollections of one-time natural or human-made disasters were related to mood, anxiety, and maladaptive coping (addiction) disorders, but not to conduct disorder (CD) or adult antisocial behavior. Adversities were stronger predictors of early-onset than of later-onset disorders. Odds of disorder onset decreased within a decade of the adversity.

As Webb (2004, and Chapter 1, this volume) points out in her discussion of tripartite assessment (see also Nader, 1997, in press; Shaw, 2000), a youth's traumatic reactions are shaped by aspects of the youth him- or herself (e.g., traits, previous experiences, neurobiology); the youth's background (e.g., genetics, socioeconomic status, culture, subculture); the nature of the event (e.g., chronicity, intensity, individual experience, personal meaning); and the pre- and posttrauma environments. Cultural issues, for example, influence coping strategies (Pole, Best, Metzler, & Marmar, 2005), support systems (Nader & Danieli, 2005; Danieli & Nader, 2006), and sanctioned reactions to trauma (Nader, in press). This chapter examines aspects of a child that influence traumatic response, the range of youth's reactions, comorbidity, and differential diagnosis.

CHILD FACTORS THAT INFLUENCE RESPONSE

Not all youth exposed to adversity develop problems or psychopathology (Yates et al., 2003). Some youth with little apparent life difficulty do develop problems. Risk and protective factors are not universally predictive of outcomes for youth (Sonderegger, Barrett, & Creed, 2004); they may be mediated by other influences. Nevertheless, aspects of youth's personalities, self-views, and other personal strengths and weaknesses often influence their characteristic reactions to stress (Davies, 2004; Nader, in press). Risk and vulnerability may interact or operate in concert.

Risk Factors

"Risk factors" are variables that are empirically associated with a disorder and predict the *increased probability* of the disorder's occurring (Ingram & Price, 2001; Nader, in press; Price & Lento, 2001). "Vulnerabilities" are a subset of risk factors that may exist in any of a youth's physiological, cognitive, affective, or social/behavioral systems. In addition to the risks created by such environmental conditions as experiences of premature birth, poverty, parental mental illness, divorce, war, and maltreatment, risk has been associated with individual traits such as negative emotionality and introversion, antisocial behavior or other conduct disturbances, poor responses to challenges, fewer or lower cognitive skills, external locus of control, and low self-esteem (Caspi, 1998; Luthar, 2003; Nader, in press; Rothbart & Bates, 1998; Yates et al., 2003). The absence or diminishment of resilience factors may add to risk.

Resilience Factors

"Resilience" suggests reduced vulnerability and the presence of protective factors. Studies have identified a number of variables that may serve as resilience factors, or, when absent, may add to risk (Nader, in press). Protective factors include personal qualities (such as intelligence, the ability to trust, a sense of self-worth, self-confidence, a realistic assessment of one's control, the ability to function well in relationships, and the capacity for appropriate self-regulation), as well as environmental conditions (such as access to needed resources, a good support system, secure caregiver–child attachments, effective parenting, and socioeconomic advantages) (Fergusson & Horwood, 2003; Nader, in press; Masten & Powell, 2003). In addition, Kessler et al. (1997) found that those who passed through the risk period associated with an adversity without developing a disorder were more resilient than the average person.

Environmental and child intrinsic factors interact. A child's personality and biochemical tendencies may elicit or repel responsive care, for example (Yates et al., 2003). Supportive, responsive, structured, and affectively stimulating environments contribute to children's self-worth, social competence, empathic involvement with others, self-confidence, curiosity, and positive affective expression. Secure attachments and the consequent youth competencies foster the development of flexible problem-solving skills, effective emotion regulation, and an expectation of success in the face of adversity (Nader, in press).

Stages of Response

The stages of response may vary for each youth or family member who has endured a traumatic experience (Nader, 2001, 2004b). Different personalities, age groups, personal histories, peritraumatic experiences, and other factors influence reactions and their progressions. Individuals exposed to the same event will have different timetables for processing aspects of the event—specific traumatic episodes and reactions such as horror, grief, and rage. Following traumas and across the course of treatment, a child or adolescent may emerge from varying degrees or stages of numbing. In order to cope, the youth may unintentionally intersperse periods of numbing and avoidance between phases of reexperiencing and arousal, or between attempts to face aspects of his or her experience and response. The youth's periodic need for avoidance of traumatic memories and thoughts can be honored across the course of his or her response while gently assisting the youth therapeutically (Nader, 1997, 2004b). When an event is perceived to be over rather than ongoing (such as the end of a war vs. ongoing conflict), or when the numbing wears off, there may be a reassessment of the experience or an aspect of it, its results, and one's role in it; of beliefs and expectations; and of the meaning of events and interactions.

THE RANGE OF CHILD REACTIONS FOLLOWING CRISIS AND TRAUMA

Traumas can have immediate and long-term effects as well as cascading effects in a young child's life (Nader, in press). Childhood traumatic experiences have been associated with childhood and adult psychiatric disorders; physical problems and disorders; academic or job-related difficulties; emotional and behavioral problems; relationship difficulties; and suicidal ideation and attempts (Boney-McCoy & Finkelhor, 1995; Kessler, 2000; Nader, in press; Silverman, Reinherz, & Giaconia, 1996; van der Kolk, 2003). In addition to formally defined disorders, traumatic experiences may result in persistent changes that dynamically influence actions and reactions in all important arenas of life. Faulty information processing, for example, may include patterns of thinking that foster violent behavioral patterns, problematic script-like or reenactment behaviors, and/or a distorted sense of self (Crick & Dodge, 1996; Dodge, Bates, Pettit, & Valente, 1995; Nader, in press; Schippell, Vasey, Cravens-Brown, & Bretveld, 2003).

A number of DSM disorders are common after trauma. These include ASD, PTSD, and various comorbid disorders (see below). Especially after chronic or severe interpersonal traumas, traumatic reactions may be more complex than the DSM-IV(-TR) diagnosis of PTSD (Herman, 1992; van der Kolk et al., 2005). The diagnosis of "complex PTSD" or "disorders of extreme stress not otherwise specified" (DESNOS) proposed for DSM-V (van der Kolk & Courtois, 2005) was not specifically included in DSM-IV or DSM-IV-TR, but many of its characteristics are mentioned as an "associated constellation of symptoms" (APA, 2000, p. 465). Because treatment methods for a simple diagnosis of PTSD may result in inadequate treatment for more complex forms of trauma, some researchers urge the inclusion of DESNOS as a separate diagnosis in DSM-V (van der Kolk & Courtois, 2005). Studies have shown that having a history of child abuse, for example, can significantly alter treatment outcomes for psychiatric conditions other than PTSD. For children, the National Child Traumatic Stress Network Work Group on Diagnosis has recommended a diagnosis of "developmental trauma." Successful treatment for complex traumatic reactions has generally been sequenced and progressive. It engages in symptom reduction and stabilization before the processing of traumatic memories and emotions, then life integration and rehabilitation (Ford et al., 2005).

Trauma-Related Disorders

Recognized disorders directly related to trauma include PTSD, ASD, dissociative symptoms/disorders, and complex trauma.

Posttraumatic Stress Disorder

In the last quarter of a century, the DSM diagnosis of PTSD (APA, 1994, 2000) has been used in the assessment of youth following traumatic experiences (Table 2.1). However, the debate continues about the applicability of DSM-IV(-TR) PTSD diagnostic criteria and algorithms to youth (Nader, in press). Although youth demonstrate the reexperiencing, numbing/avoidance, arousal symptoms, and impaired functioning found in PTSD as currently defined, it has become clear that there are variations by age and other variables in the manifestations of the disorder (Carrion, Weems, Ray & Reiss, 2002; Daviss et al., 2000; Fletcher, 2003; Nader, in press; Scheeringa, Peebles, Cook, & Zeanah, 2001). Moreover, to greater and lesser extents, all types of childhood trauma may result in developmental disruptions, in more complex forms of trauma, and in comorbid disorders. These disorders may occur immediately after or at length after traumatic experiences.

TABLE 2.1. PTSD and ASD Symptoms and the Other Disorders with Which They May Be Associated

PTSD symptom	Disorders (in addition to PTSD or ASD)
B1. Intrusive thoughts/other recollections	GAD; MD; OCD; P; SAD
B2. Distressing dreams	SAD
B3. Reenactment, reliving/hallucination, or repetitive behaviors	D; OCD; PsyD (e.g., Sch); SUD
B4. Recurrent psychological distress	Anxiety disorders; SoD
B5. Somatic complaints	CvD; Pan; PnD; SAD; SoD
C1. Avoidance of thoughts and feelings	OCD
C2. Avoidance of activities, people, and places	Ag; Ph; Sch
C3. Amnesias	AmD; DA; DID
C4. Diminished interest in activities	MD; PsyD
C5. Detachment or estrangement from others	Dep; PsyD; SUD; ScPD
C6. Restricted range of affect	Dep; MD; PsyD (e.g., P, Sch)
C7. Sense of foreshortened future/pessimistic outlook	MD
D1. Sleep disturbance	Anxiety and mood disorders in general; ADHD; Med; SUD or sub. use; Sch; SD
D2. Irritability or outbursts of anger	ADHD; CD; GAD; ODD; SUD; MD
D3. Poor concentration	ADHD; Dys; GAD; MD; ME
D4. Hypervigilance, excessive fear, or frozen watchfulness	OCD; Pan; Ph; RAD; SAD
D5. Exaggerated startle response	
Impaired functioning: academic, social, other	Any of the disorders
Absence of emotional responsiveness	Dep; Med; PsyD (e.g. catatonia); SUD
Reduction in awareness of surroundings	D; Med; SUD
Derealization or depersonalization	Med; Pan; Ph; SUD
Dissociative amnesia	Med; SUD

Note. See chapter text for a discussion of which PTSD symptoms and other criteria apply to ASD. Abbreviations for disorders in right column: AD, Asperger's disorder; ADHD, attention-deficit/hyperactivity disorder; Ag, agoraphobia; AmD, amnestic disorders; CD, conduct disorder; CvD, conversion disorder; D, delirium; DA, dissociative amnesia; Dep, depressive disorders; DID, dissociative identity disorder; Dys, dysthymic disorder; GAD, generalized anxiety disorder; MD, major depression; ME, manic episode; Med, medical disorders; OCD, obsessive–compulsive disorder; ODD, oppositional defiant disorder; P, paranoid schizophrenia; Pan, panic attack or disorder; Ph, phobia; PnD, pain disorder; PsyD, psychotic disorders; RAD, reactive attachment disorder; SAD, separation anxiety disorder; Sch, schizophrenia; ScPD, schizoid personality disorder; SD, sleep disorders; SoD, somatization disorder; SUD, substance use disorders. Table copyright 2006 by Kathleen Nader.

Acute Stress Disorder

Following traumatic experiences, ASD lasts a minimum of 2 days and a maximum of 4 weeks (APA, 1994, 2000). It requires only one symptom from each of DSM-IV(-TR) PTSD Criteria B, C, and D (Table 2.1), plus impaired functioning (social, occupational, pursuit of a task) and at least three dissociative symptoms (see below). For adults and youth alike, however, researchers have found that the dissociative symptoms of ASD have added little to its power to predict ongoing difficulties (Kassam-Adams & Winston, 2004; Meiser-Stedman, Yule, Smith, Glucksman, & Dalgleish, 2005).

Dissociative Symptoms and Disorders

Dissociative symptoms may occur as a part of ASD, PTSD (e.g., flashbacks, splitting of consciousness), or other specific disorders such as dissociative identity disorder (DID). Dissociative symptoms may be pathological or nonpathological (see Nader, in press). These symptoms have been examined as a set of symptoms on a continuum from extreme (e.g., separate identities) to innocuous (e.g., daydreaming), or as a completely separate construct that is inherently pathological (e.g., DID; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997; Putnam, 1997; Silberg, 1998). Pathological dissociation has been described as a disturbance in the integrative functions of identity, memory, and consciousness (APA, 1994, 2000; Putnam, Helmers, & Trickett, 1993). Although dissociative symptoms may occur without identifiable traumatic precursors, severe disorders such as DID in children and adolescents have often been attributed to severe stressors such as chronic physical and sexual abuse, or (in some cases) to repeated surgical procedures or imitation of family dissociative disorders (Silberg, 1998, 2004).

Complex Trauma

Complex PTSD or DESNOS is most commonly associated with interpersonal, early, extreme, or prolonged stressors (APA, 1994, 2000; Pearlman, 2001; van der Kolk & Courtois, 2005). Although complicated traumatic reactions have been documented more frequently for such stressors (APA, 1994, 2000; Terr, 1991; van der Kolk et al., 2005), complex trauma has also occurred after later and single-incident traumas such as natural disasters (Nader, 1997; van der Kolk et al., 2005). The symptoms of complex trauma have been organized in more than one way (APA, 1994, 2000; Herman, 1992; Pearlman, 2001; van der Kolk, 2003; Williams & Sommer, 2002; Wilson, 2004). Herman (1992) arranged 27 symptoms of complex trauma into seven categories: dysregulation of or alterations in (1) *affect and impulses* (difficulties with affect regulation, risk taking, anger modulation, self-destructive behaviors, suicidal preoccupations, sexual modulation); (2) *attention and consciousness* (amnesia, transient dissociative episodes); (3) *self-perception* (guilt, shame, minimizing, feeling that nobody can understand, sense of ineffectiveness, feeling permanently damaged); (4) *percep-*

tion of the perpetrator (distorted beliefs about, idealization of, or preoccupation with hurting the perpetrator); (5) *relationships with others* (inability to trust, revictimization, victimizing others); (6) *somatization* (chronic pain, conversion symptoms, sexual symptoms, digestive disturbances, cardiopulmonary symptoms); and (7) *systems of meaning* (hopelessness or despair, loss of previously held belief systems) (van der Kolk et al., 2005). Briere and Spinazzola (2005) group complex trauma symptoms into the following overlapping categories: (1) *altered self-capacities* (dysfunctions in identity, affect regulation, and interpersonal relatedness); (2) *cognitive disturbances* (altered information processing or schemas associated with, e.g., low self-esteem, self-blame, helplessness, hopelessness, pessimistic expectations of loss, rejection, and danger); (3) *mood disturbances* (affective symptoms or disorders—anxiety, depression, anger, or aggression); (4) *overdeveloped avoidance reactions* (dissociation, substance abuse, suicidality, or tension reduction behaviors such as bingeing–purging and self-mutilation that distract or invoke stress-incompatible affect); and (5) *posttraumatic stress* (PTSD reexperiencing, avoidance/numbing, and arousal). The symptoms of altered self-capacities have been specifically linked with the symptoms of suicidality, impulse control problems, substance abuse, and tension reduction behaviors (Briere & Spinazzola, 2005).

Other Disorders

Other and comorbid disorders are common for traumatized individuals (Nader, in press; see "Differential Diagnosis," below). Adults with a history of trauma have demonstrated dissociative, depressive, substance use, anxiety, personality, psychotic, and medical disorders (Gold, 2004; Kimerling et al., 2004; Krug, 1996) Disorders found in association with PTSD for youth are attention-deficit/hyperactivity disorder (ADHD), CD, depressive disorders (e.g., major depression or depressive disorder not otherwise specified), oppositional defiant disorder (ODD), phobic disorders (e.g., social or specific), and other anxiety disorders (e.g., separation anxiety disorder, panic disorder) (Carrion et al., 2002; Cicchetti, 2003; Ford, 2002; Greenwald, 2002; Udwin, Boyle, Yule, Bolton, & O'Ryan, 2000; Weinstein, Stafflbach, & Biaggio, 2000; van der Kolk et al., 2005). For both youth and adults, substance use and eating disorders have been associated with childhood traumas (Pasquini, Liotti, Mazzotti, Fassone, & Picardi, 2002). The relationship between PTSD and other disorders can be bidirectional. For instance, depression is both a possible result of PTSD and a risk factor for the development of PTSD (Kimerling et al., 2004).

Alterations in Information Processing

Trauma may alter categorization and interpretation of experience, including attention, expectations, and enactments toward self and others, as well as patterns of cognitive associations (Mash & Dozois, 2003; Nader, in press; van der Kolk, 2003; Yee, Pierce, Ptacek, & Modzelesky, 2003). For example, depressed youth may engage in negative self-evaluations, set unrealistic and perfectionistic goals, believe that efforts to achieve goals are futile, or feel hopeless or pessimistic about the future (Hammen & Rudolph, 2003). Actions based on faulty information processing may result in reactions from others that confirm the faulty information processing (Caspi, 1998; Nader, in press).

Aggression

The commission of violence has been indirectly and directly linked to exposure to violent and other traumas such as natural disasters (see Buchanan, 1998; Kohly, 1994; Nader, 1997, in press; Simmons & Johnson, 1998). In addition to its association with trauma, aggression has been correlated with traits, information-processing tendencies, neurochemistry, experience, and aspects of parenting and socialization (Aber, Brown, & Jones, 2003; Barry, Frick, & Killian, 2003; Dodge et al., 1995; Laird, Jordan, Dodge, Pettit, & Bates, 2001; Nader, in press; Scheff, 1997; Volkan, 2001). Temperamental characteristics and early experiences may set up anticipatory attitudes that affect behaviors and relationships (Caspi, 1998). Abused youth, for example, may perceive, interpret, and make decisions about social interactions that increase the likelihood of their aggressive acts (Crick & Dodge, 1996; Dodge et al., 1995). Overtly aggressive youth tend to make more hostile attributions, generate more aggressive responses, and more frequently expect rewards from aggressive problem solving (Crick, 1995).

Script-Like Reenactments

Intense traumatic impressions become etched into a youth's memory following traumatic experiences (Terr, 1991). Multiple intensely registered impressions include, for example, the experience of an immobilized onlooker, a person in flight from danger, or a defender; horrible images, sounds, and physical sensations; and strong desires or compulsions to act—to intervene, rescue, fight back, attack the source of danger, or take other action (Nader, 1997; Nader & Mello, 2001; Pynoos & Eth, 1986; see Nader & Mello, 2001, for a more complete list). These impressions influence a traumatized youth's behavior toward and thinking about self and others. Consequently, in addition to the thoughts and images that may repeatedly intrude following traumatic events, traumatic impressions may replay behaviorally in repeated enactments of *trauma-related roles* or *trauma-engendered scripts* (Nader, in press). The attributional biases related to these scripts may include altered expectations of protection and the trustworthiness and personal value of self and others (Thomas, 2005). These script-like reenactments may play out across the lifespan in the roles of persecutor, rescuer, victim, immobilized witness, and comforter, among others (Ford, 2002; Liotti, 2004; Nader, in press; Nader & Mello, 2001).

Neurobiological Changes

Research has documented reductions in brain volume and neurochemical changes following traumatic experiences (Bremner, 2003; De Bellis et al., 1999; Sapolsky, 2000). Such changes as a result of severe or prolonged trauma may have profound, compounding, and long-term effects on a child's life and development (Nader, in press). These neurobiological changes can affect cognitive, behavioral, and emotional functioning—"the way youths greet the world, function in it, interact with others, cope with adversity, and respond to life's challenges" (Nader, in press; see also Sapolsky, 1998).

DIFFERENTIAL DIAGNOSIS: DISTINGUISHING PTSD AND ASD FROM OTHER CLINICAL DIAGNOSES

Overlapping symptoms among disorders may make differential diagnosis difficult (Table 2.1). The descriptions of Jake (Box 2.1) and Billy (Box 2.2) demonstrate the overlap in symptoms and the difficulty in determining a diagnosis (see Table 2.2). Exposure to an actual traumatic experience often helps to distinguish the anxieties of other disorders from those of simple or complex PTSD or ASD. For DSM disorders, a PTSD diagnosis, if possible, supersedes other diagnoses when symptoms are directly related to a DSM PTSD Criterion A experience.

Adjustment Disorder

Adjustment disorder—clinically significant behavioral or emotional symptoms in response to one or more identified stressors—has been used when posttraumatic symptoms do not meet the specified algorithms for a PTSD diagnosis (one reexperiencing, three numbing/avoidance, and two arousal symptoms plus functional impairment) (APA, 1994, 2000; Cohen & Mannarino, 2004). As noted earlier, debate continues regarding the application of these algorithms to youth (Fletcher, 2003; Nader, in press; Scheeringa et al., 2001). Children with subsyndromal PTSD have demonstrated clinically significant traumatization (Carrion et al., 2002; Daviss et al., 2000; Nader, in press; Vila, Porsche, & Mouren-Simeoni, 1999). Future diagnostic criteria may take into account the differences across ages in the presentation of PTSD, the possibility of complex trauma without PTSD, and the developmental impact of individual symptoms and posttraumatic changes.

Anxiety Disorders

PTSD is classified among the anxiety disorders in DSM-IV(-TR) and shares several symptoms with other anxiety disorders, although it can be distinguished from them in various ways. The anxiety associated with obsessive–compulsive disorder (OCD) includes such concerns as being contaminated, repeated doubts, a need to have things in particular order, aggressive or horrific impulses, or sexual

TABLE 2.2. Differential Diagnosis

Symptom	Jake (age 10)	Billy (age 12)
Intrusive thoughts/other recollections	Games about killing others with a magic wand	Images of the shooter and others who were shot, the bullets coming toward him, the screaming . . .
Distressing dreams	Nightmares about being in danger	Nightmares of being shot at or being in other danger
Reenactment, reliving/hallucination, or repetitive behaviors		Repetitive aggressive behaviors in response to reminders of event
Recurrent psychological distress	Anxious in general; hyperventilates when stressed	
Somatic complaints	Stomachaches when stressed	Nausea in response to specific food odors
Avoidance of thoughts and feelings	Will not talk about distress; just does not answer questions	Sometimes just doesn't feel anything; goes to sleep when cannot avoid reminders of experience
Avoidance of activities, people, and places	Avoidance of all health care professionals	Will not go into the cafeteria at school
Diminished interest in activities		
Restricted range of affect	Affect often blank or negative; is often angry	Lack of positive emotions
Sense of foreshortened future/pessimistic outlook	Expects bad things to happen	Thinks he will not live to be 21
Sleep disturbance	Must have covers tightly around him in order to sleep	Excessive sleep in the day; interrupted by nightmares at night
Irritability or outbursts of anger	Frequent angry outbursts; constant irritability; aggressive to family and peers	Impulsive reactivity; angry outbursts
Poor concentration	Concentration can be interrupted by anxieties	Impossible to concentrate for any length of time
Hypervigilance, excessive fear, or frozen watchfulness	Excessive fear; wariness toward others; cautions about being approached	Always watching to see if there is danger in his vicinity
Exaggerated startle response		
Impaired functioning: academic, social, other	Social functioning is problematic; will not cooperate with medical practitioners	Impaired academic functioning; associates only with aggressive youth; does not have the concentration to work
Diagnosis	Sensory integration dysfunction; neurological tests pending	PTSD; complex trauma with antisocial and self-destructive behaviors

Note. Table copyright 2006 by Kathleen Nader.

BOX 2.1. Excerpts from the Case of Jake

HISTORY

Symptoms

Jake has a history of aggression toward his family and sometimes toward his peers. He does not seem to have empathy for others. His parents describe him as stubborn, defiant, and uncommunicative. He sometimes angrily refuses to obey his parents. In contrast, after his sister goes to bed, he becomes a calm, likeable boy in the nurturing presence of his parents. He is fearful of being alone and fearful in general. When something triggers stress, he hyperventilates or has a stomachache. . . . His excellent intelligence can be interrupted by stress or an inability to concentrate or keep focus. He has frequent angry outbursts. He is cautious or angry toward others. . . .

Jake currently engages in poor self-care (e.g., does not want to brush his teeth). He is afraid of all health care practitioners and refuses to cooperate with them. . . . Jake cannot sleep at night unless the covers are tightly wrapped around him.

Jake's symptoms are exacerbated by noise or commotion. Rhythmic motion and music soothe him. . . .

Family History

Jake's parents are intelligent and caring caregivers. Both of his parents have a history of depression and anxiety. Jake's younger sister is charming and has a comfortable relationship with both parents. Although he is sometimes comfortable in dyads under nurturing circumstances, Jake's relationship with his family has been frequently strained. . . .

PRESENTATION IN INTERVIEWS

Jake is an intelligent, attractive 10-year-old boy. . . . Jake appears to be very cautious with other people. He looks warily at individuals who enter his proximity. He is on alert when being approached. He often does not respond to greetings or to questions from others. . . . He tenses when approached and looks ready to fight or protect himself. . . . Jake sometimes behaves defiantly or with intense resistance. He exits when a situation no longer holds interest or reward for him. . . . He reports negative expectations of the future. . . .

DIAGNOSIS

Jake's diagnosis on referral was sensory integration dysfunction. He responded well to occupational therapy that included methods of rhythmic activity and techniques that soothe or gather focus. . . .

Tests ordered: EEG, neurochemical tests

Rule out: ADHD, low-cortisol aggression

BOX 2.2. Excerpts from the Case of Billy

HISTORY

Symptoms

Billy's mother reports a history of aggression. He lashes out if anyone grabs an arm or a shoulder. Sometimes he just wants to fight someone. He has nightmares at night and falls asleep during the day. Billy was formerly a good student and a happy boy. Now he is in a special class because of his disruptive behavior and inability to concentrate or remember. He cannot eat in the school cafeteria because the smells of some foods make him nauseated. He is always aware of his surroundings and seems to need to know whether there is possible danger. . . . Teachers describe him as defiant now. . . .

Event

On a hockey day, Billy was in his hockey shirt like the other players. When he was walking down the hall, a boy came up to him, grabbed his arm, and yelled something like "You think you're so great, big hockey player!" Later Billy was in the cafeteria eating with the other players when the same boy came in with a gun and started shooting at the players. A few of the players had made fun of him on more than one occasion. Billy saw the first bullets hit his fellow players and saw the blood and tissue flying across the table. Billy saw the bullets coming toward him, almost as if in slow motion. He sat frozen at first and was jarred into action by the impact of the first bullet. He dove under the table. . . .

DIAGNOSTIC INTERVIEWS

Billy is 12 years old. . . . Billy calmly stated that he did not need to see a shrink. He was quietly and resistantly cooperative at first. Then he seemed to relax and provided thorough information in response to questions. He said that he could not stand to think about the shootings. He just wanted to sleep. He said that he didn't feel anything most of the time, but must be angry because he just wanted to punch someone. He wanted to fight. . . . Billy is highly reactive in response to reminders of the event. When someone grabs his arm or shoulder the way the shooter grabbed him, he just swings at him or her. He doesn't think about it first; "it just happens." . . . "After the shooting, people were screaming and running and throwing up. I just can't go back in there without feeling sick to my stomach." . . .

DIAGNOSIS

Inaccurate diagnosis: Conduct disorder Accurate: PTSD imagery (APA, 1994, 2000). However, OCD involves preoccupations produced internally (in the mind), in contrast to posttraumatic imagery, which arises from a traumatic experience. The repetitive thoughts of OCD are also often experienced by the individual as inappropriate (APA, 1994, 2000). In OCD, repetitive thoughts and actions that constitute compulsions are engaged to counteract recurrent thoughts, actions, images, or impulses (obsessions) (McNally, 2001). By contrast, posttraumatic cognitive, behavioral, or physiological repetitions reproduce aspects of the traumatic experience, are a part of reexperiencing the trauma, and may include attempts to process or master aspects of the experience (Horowitz, 1975).

Separation anxiety disorder (SAD) may follow traumatic exposure and may accompany PTSD or ASD. That is, youth may develop intense worry about being away from home or family (APA, 1994, 2000; Nader & Pynoos, 1993). When they occur posttraumatically, these fears may reflect fear about a recurrence of the trauma and ongoing concerns about personal safety (Pynoos & Nader, 1988; Shaw, 2000).

The phobic-like fears and avoidances associated with PTSD can be distinguished from phobic disorders, in that PTSD follows a specific stressor event and includes additional symptoms of avoidance and numbing, reexperiencing, and arousal symptoms (APA, 1994, 2000). Things feared or avoided are directly linked to the trauma or the time leading up to or following it. Following traumatic experiences, youth may avoid social situations for a number of reasons: because (1) stimuli (e.g., noise, motion, emotion) become overwhelming; (2) youth feel unsafe in crowds or away from caretakers; (3) people remind the youth of the traumatic experience and thus cause distress; (4) youth feel humiliated or embarrassed because of having been victimized or because of traumatic injuries; (5) trust or self-esteem has been damaged; or (6) irritability or anger makes relationships difficult. Fear of possible humiliation is prominent in social phobia (APA, 1994, 2000), but in PTSD or ASD, fear of humiliation is related to the traumatic experience or engendered by it through altered information processing.

Somatoform Disorders

Members of some cultures (e.g., Asian or Hispanic cultures) may present with somatic complaints rather than other symptoms of trauma (Kinzie, Boehnlein, & Sack, 1998; Pole et al., 2005; Shiang, 2000). In contrast to somatization disorder, the physical complaints associated with trauma occur among other anxieties and symptoms (with some cultural exceptions). Depression, anxiety, somatic complaints, and psychotic-like behaviors (for dissociative or disorganized youth) may occur in combination among traumatized youth (Cohen & Mannarino, 2004). Pain symptoms are common to depressive, anxiety, and psychotic disorders (APA, 1994, 2000). For pain disorder, in contrast to PTSD and other disorders, pain or multiple physical complaints are an independent clinical focus. The neurobiology of extreme stress can inhibit immune functioning (Sapolsky, 1998). In all cases, actual medical disorders must be ruled out in the process of diagnosis.

Dissociative Disorders

As discussed earlier, dissociative symptoms may accompany PTSD, are possible in complex trauma, and are essential to ASD. Dissociative symptoms occur as aspects of other disorders and circumstances as well. Dissociative symptoms and disorders such as amnesia, for example, may occur as a result of medical disorders, substance use, seizure disorders, or brain injury. DID has often been linked to severe and repeated traumas (Silberg, 1998). For DID, it may be necessary to distinguish between the existence of separate identities and auditory hallucinations (e.g., in schizophrenia) or the shift between cyclical mood states (e.g., in bipolar disorders).

Psychotic Disorders

Under particular conditions, severely traumatized youth may be likely to display transient psychotic symptoms (Cohen & Mannarino, 2004). Severely abused or incarcerated and tortured youth, for example, may display psychotic symptoms when frightened by being restrained on an inpatient psychiatric unit. Dissociative symptoms such as disorganized behavior, flat affect, and social withdrawal may have a similar presentation to psychotic disorders.

Disruptive Behavior and Impulse Control Disorders

The impulsiveness common to ADHD, CD, ODD, and PTSD may reflect neurochemical commonalities. Moreover, ADHD and traumatic reactions have some symptoms in common. Indeed, a diagnosis of ADHD can be misdiagnosed PTSD (Greenwald, 2002). Traumatization may also include difficulties concentrating, fidgeting, impatience, difficulty delaying responses, and disruptive behaviors. Fidgetiness and difficulty sitting still may reflect posttraumatic jumpiness, nervousness, and hypervigilance. Both disorders may include disturbed sleep patterns. Difficulties with impulse control and intermittent explosive behaviors may occur following traumas. Impulse control disorders are not diagnosed when the impaired impulse control is an aspect of PTSD (APA, 1994, 2000).

Youth with CD violate the rights of others or major societal age-appropriate norms or rules (APA, 1994, 2000). Several studies suggest an association of traumatization with CD and ODD (Ford, 2002). The two disorders have symptoms in common with PTSD. Like youth with CD, previously well-behaved youth who have been traumatized may exhibit bullying or threatening behaviors, initiate fights, engage in other aggression, and otherwise violate rules and norms. Like youth with ODD—which involves limit testing, disobedience, defiance, negativity, and hostility toward authority figures (APA, 1994, 2000)—traumatized youth may exhibit defiance, easy loss of temper, quick annoyance, anger, resentfulness, negativity, hostility, and verbal aggression. Ford (2002) points out that posttraumatic oppositional refusal to follow rules or engage in particular activities may reflect the persistent posttraumatic avoidance of reminders of the trauma.

Sleep Disturbances

Sleep disturbances occur as associated symptoms of a number of disorders, such as mood or anxiety disorders (APA, 1994, 2000). If the sleep disturbance associated with PTSD becomes severe enough, it may be included as a separate diagnosis. Sleep disturbances may contribute to other symptoms, such as deficits in concentration, memory, energy, feelings of well-being, motivation, and mood, as well as increases in clumsiness, fatigue, and malaise (APA, 1994, 2000; Nader, in press). A diagnosis of nightmare disorder is not applied separately if nightmares occur as symptoms of PTSD. Adults have experienced a reduction of other trauma symptoms after treatment for nightmares (Krakow, Hollifield, et al., 2001). Similar treatment of a small group of adolescents reduced nightmares but did not diminish concurrent symptoms (Krakow, Sandoval, et al., 2001).

Personality Disorders

Although personality disorders are not diagnosed for this age group, they have been identified among the long-term consequences of childhood trauma (Herman, 1992; Krug, 1996). A personality disorder (PD) "is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible . . . and leads to distress or impairment" (APA, 1994, p. 629). Recognition of the early signs and symptoms of such disorders may assist preventive interventions. Care must be taken in interpreting behaviors, however, because (1) a dimensional, rather than a categorical, perspective suggests that PDs represent maladaptive variations of personality traits, and (2) symptoms otherwise associated with PDs are reasonably expectable following exposure to traumatic events. The distrust and suspiciousness of paranoid PD; the social detachment and restricted range of affect common to schizoid PD; the impulsivity and instability of affect, self-image, and relationships associated with borderline PD; the hypersensitivity to negative evaluation, feelings of inadequacy, rigidity, and social inhibition linked to avoidant PD; the clinging and submissiveness of dependent PD; and the obsessive thoughts and need for control associated with obsessive–compulsive PD can occur following exposure to traumatic events (APA, 1994, 2000; Price & Lento, 2001). Because of the overlap in symptoms, DSM (APA, 1994, 2000) advises caution in using PD diagnoses during an episode of a mood or anxiety disorder.

ASSESSMENT MEASURES

This section provides brief descriptions of a number of the trauma assessment measures that include PTSD and additional symptoms found for children. Measures continue to be updated as information about childhood trauma increases. Most scales and interviews include associated scales or items to assess exposure and additional trauma-related difficulties. The scales presented here have good or acceptable psychometric properties and are discussed in more detail in Nader (in press). Those that assess multiple disorders generally assess the symptoms of all DSM disorders. The trauma scales described here include a more thorough examination of trauma-related symptoms, in addition to those identified for the DSM adult disorder. Trauma scales that assess only DSM-IV PTSD without additional symptoms may miss some of the symptoms important to treatment.

Preschool Children

Parent report scales that address trauma in preschool children are presented here.

The PTSD Semi-Structured Interview and Observational Record for Infants and Young Children (PSIOR; Scheeringa & Zeanah, 2005) elicits reports from parents of children under the age of 6. Version 1.4 includes traumatic exposures and developmentally sensitive trauma items for children less than 48 months old. Items focus on observable behaviors. Observation of a child during the caregiver interview provides supplemental information (Scheeringa et al., 2003). The interview permits a diagnosis either by the DSM-IV PTSD algorithm or by proposed alternative algorithms (Scheeringa et al., 2003).

The Preschool Age Psychiatric Assessment (PAPA; Egger, Ascher, & Angold, 2002) is a structured parent or guardian interview that collects developmentally relevant symptoms and impairment information on a variety of disorders, including trauma/PTSD. The parent interview includes subsections for background and symptom information, disorders found in young children, life events, and PTSD A events (stressor events occurring in the last 3 months), and PTSD B events (lifetime major traumatic events). Psychiatric diagnoses are generated by computerized algorithm after the interview.

The Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005) is a 90-item caretaker report measure developed to assess trauma-related symptoms in children ages 3–12. The TSCYC asks about observable behaviors. Two validity scales determine Atypical Responses (overreporting) and Response Level (underreporting). A DSM-IV PTSD diagnosis is possible from the parent scale. Normative data are available for gender and age subgroups (3–4, 5–9, and 10–12 years).

School-Age Youth

Described below are youth self-report scales that assess PTSD and other posttraumatic symptoms (see Nader, in press, for more details). In addition to these scales are those that assess multiple disorders, such as the Missouri Assessment of Genetics Interview for Children (Reich & Todd, 2002); the K-SADS (Puig-Antich & Chambers, 1978); and the Child and Adolescent Psychiatric Assessment (Angold, Cox, Prendergast, Rutter, & Simonoff, 2000). In individual clinical interviews, rapport building should precede the use of assessment measures. Among rapport-building methods are (1) the demonstrated sanction of caretakers and, when applicable, those in authority (such as teachers or school administrators); (2)

introduction of the clinician as one who works with children who have been through something like the traumatic event, or one who works with children like the youth; (3) the genuine interest and responsiveness of the interviewer; and (4) draw-a-picture, tell-a-story techniques.

The Child Posttraumatic Stress Reaction Index (CPTS-RI; Frederick, Pynoos, & Nader, 1992) is a 20-item scale, and the Additional Questions for this scale (Nader, 1999a) include 11 main questions (and 48 probe or clarification questions) (Nader, 1993, 1999b). Although the CPTS-RI will remain available to provide a trauma level that correlates well with DSM-IV PTSD, the 1992 scale is a precursor to scales under development by Nader and Fletcher that will be available in 2007. The revised scales will include DSM-IV-TR PTSD, additional symptom, and complex symptom subscales for diagnoses of PTSD, ASD, complex trauma, developmental trauma, faulty information processing, and other posttraumatic symptoms or impairments.

When Bad Things Happen (WBTH; Fletcher, 1991) assesses DSM-IV PTSD, DSM-III-R PTSD, and associated symptoms. A rating scale with a coding key accompanies the WBTH, assisting computation of the DSM-III-R or IV diagnosis or a continuous score. A computer-scoring program, and a tape to assist younger children and those with reading difficulties in completing the instrument, are also available.

The Children's Impact of Traumatic Events Scale–2 (CITES-2; Wolfe & Gentile, 2003) includes DSM-IV PTSD diagnostic criteria and additional items. The CITES-2 permits the examination of sexually abused and other traumatized children; it assesses trauma factors, social reactions, sexual concerns, attributions (based on learned helplessness theory), and other subjective responses (e.g., loss of friends, being made fun of by others, loss of faith in adults, distrust). It also includes symptoms common to more complicated forms of PTSD. Many of the additional symptom questions are worded specifically for sexual abuse.

CONCLUSIONS

PTSD captures only a part of posttraumatic psychopathology in youth. A number of comorbid disorders, symptoms, and patterns of thought and behavior other than those described in the diagnostic criteria of PTSD occur for youth and may increasingly disrupt life across time. A number of risk and resilience factors may affect youth's traumatic reactions. Aspects of a youth as an individual, his or her background and environment, his or her individual traumatic experience and history, and the manner of assessment may interact or transact in determining the youth's reactions to adversity. There is a great deal of overlap in symptoms for the disorders of youth. PTSD and ASD are distinguished from other disorders by exposure to a Criterion A stressor event and by symptoms that relate directly to or are colored by the event. Assessment of youth must examine multiple factors and the symptoms in addition to PTSD that may occur for youth.

Study Questions

1. What are the differences between DSM-IV(-TR) PTSD and complex PTSD? Why are they important?
2. Do you think that Billy (Box 2.2) has complex trauma? Why or why not?
3. What are risk and resilience factors? Name commonly recognized ones.
4. Which symptoms of PTSD overlap with other disorders? Why doesn't Jake (Box 2.1) receive a diagnosis of PTSD?
5. Obtain one of the scales described in this chapter, and interview a classmate about a bad experience.

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Chapter 3

Crisis Intervention Play Therapy with Children

Nancy Boyd Webb

Play therapy ingeniously undertakes the hard work of child psychotherapy in the appealing guise of play. Since children think and behave differently from adults, the approach to working with them must reflect this difference. Play therapy has adapted its methods to accommodate the world of childhood, using the medium of play as the means for communicating symbolically with the child.

Few children willingly admit that they have "problems," even when their parents are at their wits' ends because of the children's nightmares, shyness, or aggressive behavior. These children are brought for therapy because of their parents' or teachers' complaints about their behavior. Furthermore, once in the therapist's office, these children cannot endure a discussion about their "problems" with a strange adult. The well-meaning but inexperienced therapist who asks a youngster the typical open-ended question appropriate for adults—"So tell me about what brings you here today"—had better be prepared for a blank stare, a shrug of the shoulders, or (at best) "My mother said you wanted to talk to me." If it is hard for adults to seek help and discuss their emotional distress in therapy, how much more so is it for children! Fortunately, play therapy techniques come to the rescue, providing initial enticement for engaging a child, and ongoing appeal during the process of treatment.

This chapter presents a model of play therapy that can be used with children who are having difficulties related to their anxieties associated with a crisis or traumatic event. The issue of directive versus nondirective play therapy is discussed, together with the current emphasis on evidence-based practice. Different play therapy methods are also discussed as potential treatment interventions for young children in crises or traumatic situations.

BACKGROUND

Play has been used in child therapy since the 1920s, when Anna Freud (1926/1946) employed games and toys as a way to build a relationship with her child patients. Another child analyst, Melanie Klein (1932), used children's play as the basis for making interpretations to the children. Other play therapy pioneers include David Levy (1938), who helped children reenact traumatic events through a structured play format, and Frederick Allen (1942), Claude Moustakas (1959), and Virginia Axline (1947), all of whom emphasized the power of the therapeutic relationship in conjunction with the therapist's belief in the child's strengths and potential for growth and change. Readers interested in a comprehensive overview and comparison of the considerable differences among the theoretical perspectives and working procedures of these early play therapists and their current followers can consult Schaefer (2003) or O'Connor (1991).

SIGNIFICANCE OF PLAY FOR CHILDREN

It is remarkable that despite the substantial differences in their theoretical orientations and approaches to treatment, play therapists all agree about the unique meaning of play to children and about the importance of understanding the symbolism of children's play language. The operating assumption is that "through the manipulation of toys the child can show more adequately than through words how he feels about himself and the significant persons and events in his life" (Ginott, quoted in Schaefer & Kaduson, 1994, p. 33). According to Bettelheim (1987, p. 35), "play is the royal road to the child's conscious and unconscious inner world; if we want to understand his inner world and help him with it, we must learn to walk this road."

DEFINITION, GOALS, AND NATURE OF PLAY THERAPY

Definition and Primary Goals

"Play therapy" is a helping interaction between a trained adult therapist and a child for the purpose of relieving the child's emotional distress by using the symbolic communication of play. "The assumption is that children will express and work through [their] emotional conflicts . . . within the metaphor of play" (Reid, 2001, p. 150). Furthermore, the play therapist not only helps bring about relief of clinical symptoms (important as this may be to parents and child), but also works toward removal of impediments to the child's continuing development, so that the prospects for the child's future growth are enhanced (O'Connor, 1991; Webb, 2003; Crenshaw, 2006).

These dual play therapy goals (i.e., symptom relief and removing obstacles to the child's development) are illustrated in the case of a 10-year-old child with a sleep disturbance. The therapist helped the child identify a number of self-soothing activities that she could employ other than going into her parents' bedroom when she woke up in the middle of the night. The successful outcome in this case (which also employed a series of planned rewards from the parents when the child did not disturb them) resulted not only in cessation of the girl's nighttime waking, but also in an increase in the child's confidence about her ability to deal successfully with her internal distress. The case illustrates both symptom alleviation and enhancement of coping abilities through the use of cognitive-behavioral methods. The play therapy with this girl utilized art techniques to help her externalize her fears on paper, and also to portray her anticipated positive mood at a future time when she would no longer feel afraid. (A full discussion of this case appears in Webb, 2003.)

In ways that will become clear in the various detailed case examples in this book, the "therapy" of play therapy involves far more than merely playing with a child. Through the interactions with the therapist, the child experiences acceptance, catharsis, reduction of troublesome affects, redirection of impulses, and a corrective emotional experience (Chethik, 2000; James, 1994). In the safety of the "holding environment" of the playroom, the child can express his or her feelings in fantasy and then eventually move to a state of mastery (Reid, 2001), which subsequently may carry over to the child's everyday life. It is important to emphasize that it is not play per se that produces anxiety relief for the child. Rather, it is play in the context of the therapeutic *relationship* that provides the critical healing process (Chethik, 2000; Landreth, 2002). Shelby (1997, p. 149) states that "traumatized children need to be heard in the presence of another who is not afraid . . . they need someone to accept their suffering in its cruel entirety."

Balance between Verbal and Play Interactions

Play therapy consists of a combination of verbal as well as behavioral interactions between the child and the therapist. Indeed, Enzer (1988) believes that assisting a child toward greater verbalization is one of the primary goals of play therapy. However, a child's ability to verbalize depends on his or her age and level of cognitive development. Winnicott (1971, p. 39) reminds us that "the child does not usually possess the command of language that can convey the infinite subtleties that are to be found in play." According to Erikson (quoted by Woltmann, 1955/1964, p. 31), "the child uses play to make up for defeats, sufferings, and frustrations, *especially resulting from . . . limited use of language*" (emphasis added). Play, however, must never become an end unto itself in play therapy. I repeatedly instruct child therapy interns and beginning child therapists that *when a child can and is willing to talk about his or her anxieties, we should listen and encourage more verbalization*. Nonetheless, the therapist working with a child in crisis understands that when the child's anxiety mounts, he or she may need to retreat from verbalized connections to his or her own life, and then playing serves as a safe refuge.

Play also serves as a crucial means for establishing the therapeutic relationship. My usual procedure in the initial session with a child is to say that I am a doctor who helps children and families with their troubles and their worries, and that "sometimes we talk and sometimes we play." This gives the child permission to use verbalization or play according to his or her particular ability, level of comfort, and preference.

Many play therapists are appropriately cautious and even reluctant about making direct verbal connections between a child's life and the symbolism they notice embedded in the child's play. When the therapist makes the child aware of the meaning behind his play, this deprives the youngster of the distance and symbolic outlet he or she needs to express his or her conflicts and anxiety. Terr (1989, p. 14) stated that "an entire treatment through play therapy may be engineered without stepping far beyond the metaphor of the game." My own experience has repeatedly verified that therapy in a displaced fashion (e.g., through family dolls or puppets) can bring symptom relief without any verbal connection from the play to the child's life. This was illustrated in the case of Michael, a 4-year-old boy who developed very aggressive behavior after repeatedly witnessing his father hitting his mother. After a session in which Michael spontaneously acted out a violent aggressive scene with family dolls, some of his troublesome interpersonal behavior began to change. During Michael's play I had repeatedly verbalized the doll's feelings (i.e., being frightened and scared), thereby helping to validate Michael's own feelings of fear and helplessness when he had witnessed a similar situation (Webb, 1999). However, I did not verbalize this connection to the child.

As a child gets older, his or her verbal communication skills usually increase, and there may be less reliance on symbolic play. Kaplan (1999) demonstrated the shifting balance among verbalization, large-muscle play activity (Nerf ball and skateboarding), and doodling in the case of an 11-year-old boy whose anxiety in discussions about his illness propelled him away from verbalization and toward physical activities that permitted him to temporarily deny the possible serious implications of his blood disorder.

Up to What Age Is Play Therapy Appropriate?

As the preceding discussion suggests, play therapy is a suitable treatment modality through late elementary school age, with the likelihood that the balance between verbal and play content will shift gradually as a child gets older. Play usually dominates over verbalization in the preschool years, whereas the opposite situation will probably prevail as the child approaches puberty. However, there is no hard and fast rule about this. Art techniques, for example, may be used as a medium for therapy throughout the lifespan, as may some board games and visualization techniques. On the other hand, some play therapy materials such as dolls may be spurned by latency-age boys who consider them "girls' toys," although these same boys will play with animal puppets, dinosaurs, and army figures, and will engage in drawing activities such as cartooning. Doyle and Stoop (1999) present the case of 10-year-old Randy with a very traumatic background, who over several directive play therapy sessions constructed a cartoon lifeline of his past and then brought it to life through play with animal puppets that represented the important people and events that he had created in the lifeline.

Terr (1989, p. 15) notes that "traumatized youngsters appear to indulge in play at much older ages than do nontraumatized youngsters." This is probably because they do not want to talk about their frightening experience. Therefore, the opportunity to play must be available to facilitate the symbolic expression of experiences that are too horrible to verbalize. This is discussed further below in the section on crisis intervention play therapy.

More about the Functions of Play Therapy

As noted earlier, the primary purposes of play therapy are (1) to help troubled children express and obtain relief from their conflicts and anxieties symbolically through play in the context of a therapeutic relationship, and (2) to facilitate children's future growth and development. In addition play therapy is of value in helping establish the treatment relationship and in facilitating the therapist's diagnostic understanding of the child's problem. It fulfills the following functions as well:

- It provides cathartic relief from tension and anxiety [Emotional function].
- It provides ways for the child to review symbolically in play what happened, to plan ahead, and to problem-solve, thereby permitting a consideration of different outcomes (problem-solving/cognitive/educational function).
- It permits role rehearsal through play, which can enlarge the child's perspective beyond the immediate situation (behavioral function).
- It can provide a restorative/transformative experience of relief and hope for better times to come (spiritual function).

Each child's situation is unique; therefore, play therapy with individual children will have a different emphasis, depending on the specific assessment of each child's problem situation and the child's particular reactions. Since the focus of this book is on play therapy with children in crisis, the discussion that follows focuses on the specific play therapy approaches that deal with children in situations of crisis and trauma.

THE PURPOSES AND FORMS OF CRISIS INTERVENTION PLAY THERAPY

Definition of the Approach

Crisis intervention play therapy (CIPT) is the appropriate model of treatment for children who have become symptomatic after exposure to a crisis or traumatic event. This approach uses all the usual play therapy methods, with the specific goal of helping the child attain mastery over his or her anxiety associated with the experience. Treatment is usually short-term and directive, relying on the safety of the therapeutic relationship to permit the child to reenact his or her stressful experience either symbolically or directly, using play materials. This approach is recommended as a primary intervention either for crisis situations that are distressing to children but not actually traumatic, or for single-event (Type I) traumas. When a child has experienced multiple (Type II) traumas, crisis intervention play therapy will still be useful as an initial intervention, but a more extended treatment model may also be needed. (See below for further discussion.)

Promoting Mastery

Shelby (1997, p. 144) comments that "children use play to move from crisis to confidence as they learn to manage their distress." She recommends an "experiential mastery-oriented technique" based on Pynoos and Eth's posttraumatic interview (1986), which encourages children to act out their revenge fantasies in play and then move beyond these to mastery experiences that encourage positive cognitions. Erikson (1950/1964) also viewed play as a child's means of achieving mastery over traumatic experiences. The make-believe element, according to Woltmann (1955/1964, p. 24), "eliminates guilt feelings which would appear if action could result in real harm and damage and enables the child to be victorious over forces otherwise above his reach and capacity."

In a crisis or traumatic situation, the child has felt helpless and afraid. Through review of the experience in play, the child transforms his or her feelings of passivity and impotence into feelings of activity and power. Instead of being the hurting patient, the child becomes the administrator of pain in his or her fantasy. Thus, for example, a child who has been subjected to painful medical procedures may earnestly play out giving injections and other treatments to a doll in doll play.

Directive versus Nondirective Play Therapy

As mentioned previously, many of the founders of play therapy subscribed to a nondirective approach. Their philosophy emphasized that the child can and should lead the way, and that the role of the therapist is to support and follow the child's lead. This strengths-based model, labeled by Landreth (2002) as "child-centered therapy," often proves to be a long-term approach that does not focus on the presenting problem, crisis, or traumatic event unless the child chooses to play this out spontaneously.

Sometimes a child's posttraumatic play takes the form of secretive, monotonous, ritualized play, which fails to bring any relief. Terr (1983) describes this type of play in 26 children in Chowchilla, California, who were overwhelmed with anxiety following the sudden and intense traumatic experience of being kidnapped and buried alive for 16 hours in a school bus. Based on her work with these children, and on a review of the literature, Terr (1983) believes that a severely traumatized child needs to verbalize as well as to play. She recommends a form of directive child psychotherapy using preset or prearranged play, in which the therapist deliberately encourages the child to reenact the trauma by providing the child with play materials suggestive of the traumatic experience.

This psychotherapeutic reconstruction includes a verbal review of the traumatic experience, in which the therapist helps the child obtain relief from feelings of guilt and fear associated with the trauma. Examples of such directive play reconstruction include work with a 9-year-old refugee (Bevin, 1999) and trauma-focused cognitive-behavioral therapy with a 6-year-old girl (see Neubauer, Deblinger, & Sieger, Chapter 6, this volume).

David Levy's (1938, 1939) early work with traumatized children, which he termed "release therapy," "abreaction therapy," and "control play," represented landmark treatment using directive approaches that were in former years referred to as "preset" or "prearranged" play. Unlike Terr (1983), Levy did not use verbalization, nor did he interpret a child's feelings during the play. "In release therapy the interpretive function of the therapist is reduced to a minimum and may be absent, especially in children age 2, 3, and 4" (Levy, 1939, p. 716). Therefore, Levy's model represents a combination of directive (providing the trauma-related play materials) and nondirective (no verbalization or instructions from the therapist) play therapy.

Often children (and adults) do not want to remember their frightening crisis experiences. Avoidance is typical following a crisis or traumatic event (American Psychiatric Association, 2000), and the child's reluctance to review his or her anxiety-evoking memories presents a challenge to the therapist, who knows that pushing worries away does not cause them to disappear. In fact, the prevailing practice wisdom recommends that in order for traumatic experiences to be resolved, some form of retrospective review is usually necessary (Amaya-Jackson & March, 1995). As will be discussed in the next section, directive, crisis/trauma-focused play therapy can help a child to gradually process anxious feelings and to learn methods to put these in the past, so that they no longer hold center stage in the child's present emotional life.

This perspective is congruent with the views of cognitive therapists (Deblinger & Heflin, 1996; Cohen, Mannarino, & Deblinger, 2006), who emphasize not only the importance of the stressful/traumatic play reenactment, but also the need for mental reworking or "cognitive restructuring" of a trauma event. This entails a verbal review that brings about a changed outlook on the experience, through repeated guided interactions in which the therapist directs the child to imagine and describe a different desired outcome to the stressful event. Some specific methods in this cognitive approach might include the use of calming and relaxation techniques, guided imagery, psychoeducation, positive self-talk, and instruction that the child should rely on parents and other competent adults in dangerous situations.

Research has not yet provided definitive conclusions about whether directive or nondirective approaches bring more favorable results in therapy with symptomatic children following crisis or traumatic events. Shelby and Felix (2005) comment that throughout the history of child trauma therapy, there has been debate about how best to intervene. Despite the lack of consensus, Amaya-Jackson and March (1995) argue for a combination of cognitive-behavioral, supportive, and psychodynamic psychotherapy to help traumatized children. However, as yet no studies have examined the efficacy of this combined approach. In view of the lack of agreement (and lack of conclusive empirical research findings), it seems understandable that few child therapists currently rely on a *purely* directive or *purely* nondirective treatment approach. An assessment of the child—either tripartite assessment (see Chapter 1), the use of other assessment instruments (such as those listed in Chapter 2, or both—can lead to a treatment approach that considers the child's personal attribution of meaning related to his or her crisis/traumatic experience.

In the absence of firm, empirically based recommendations for the treatment of children who have experienced crisis and trauma, this book offers examples of a variety of child treatment methods. Ideally, more research in the future will lend light on this important topic; until then, methods that combine both directive and nondirective treatment will continue to be used to relieve children's distress.

PLAY THERAPY FOR DIFFERENT TYPES OF CRISES/TRAUMAS

In Chapter 1, I have defined the terms "stress," "crisis," and "trauma," and have presented a figure illustrating the interaction of stress, crisis, and trauma (see Figure 1.2). I have also discussed Terr's (1991) distinction between Type I (single-event) and Type II (multiple) traumas. As Figure 1.2 indicates, a crisis or traumatic event may be dealt with through adequate or inadequate coping. We know that many people, including children, are sufficiently resilient to endure various frightening or even terrifying experiences without developing distressing symptoms (although this is more often the case with crises that are not actually traumatic and with Type I traumas than it is with Type II traumas). In other cases, however, individuals' temperament, personal history, and/or current life situation do not permit them to cope adequately with a crisis or trauma. Figure 1.2 shows that such individuals may develop anxiety, depression, or various posttraumatic symptoms. As Nader discusses in detail in Chapter 2, the symptoms of youth exposed to traumatic events may meet formal *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria for a diagnosis of posttraumatic stress disorder (PTSD) or acute stress disorder (ASD), as well as a wide variety of comorbid disorders, although both she and other authors (Shelby, 1997; Scheeringa, Zeanah, Drell, & Larrieu, 1995) maintain that the DSM does not adequately represent children's typical responses to crisis or trauma. Nevertheless, play therapy crisis intervention is based on the hope that timely intervention may help children who have undergone crises or traumas either to resolve their related anxieties and other symptoms before they blossom into full-blown psychiatric disorders, or to return more rapidly to normal functioning if they already meet criteria for one or more disorders.

The cases that follow present the use of crisis intervention play therapy (CIPT) with children who have experienced Type I and Type II Traumas (Terr, 1991). The first involves a 9-year-old girl, Susan, who was functioning well until she suffered the sudden, traumatic loss of a friend in a car accident (Type I trauma). The second case describes a series of traumatic events that occurred to a 10-year-old boy, Sergio, a refugee from Central America who almost drowned while fleeing from Mexico over the Rio Grande, and who then witnessed his mother's rape, followed by their subsequent flight to safety (Type II traumas). In both cases the crisis intervention therapists acknowledged and empathized with the children's frightened feelings and attempted to clarify any cognitive distortions, while also emphasizing the children's good survival strategies, coping abilities, and current safety. Both of these cases have been previously published (Webb, 2002; Bevin, 1999; see Webb, 2006a, for a summary of both cases) and were summarized by Webb in Carey (2006). They are presented here in greatly abridged form, to illustrate the use of directive and nondirective methods in crisis intervention play therapy after a single-incident trauma and after a situation of multiple traumatic events.

The Case of Susan, Age 9

Family Information

Susan, age 9, was in fourth grade and active in Girl Scouts. Susan's family and Carl's had been very close for many years.

The Traumatic Event

On a sunny afternoon, Carl's mother was driving him home from school when the car went off the road and a tree branch came through the car window, piercing Carl's body; he died on the scene. The rumor in the community and in Susan's school was that the branch had decapitated the boy! Although this was not in fact true, *everybody* at school and in the community whispered about Carl's horrible form of death. Only years later did Susan learn the true cause of her friend's death—namely, that the branch had pierced his stomach and he had bled to death on the spot. This is an example of a rumor taking on a reality of its own that was so horrible no one could discuss it.

Reason for Referral

Susan's behavior changed quite drastically following Carl's death. Since the accident, she had become "angry, cranky, and mean"; she had stopped doing her homework and after school would stay in her room, saying that she was "tired." She was also complaining of headaches and bad dreams every night. Susan had not shed a single tear at Carl's funeral, and she refused to go to his house to speak with his mother or sister. Furthermore, Susan would become agitated and panicky whenever her mother drove anywhere near Carl's neighborhood. She came very close to qualifying for a diagnosis of ASD.

Play Therapy Sessions

Although Susan had initially refused to come into my office, she did so after I went outside to greet her. In the first session, I told Susan that I knew about her friend's terrible death, and I explained my role as a doctor who helps kids with their troubles and worries. Susan told me about her nightmares, and I empathized with her about them, saying that sometimes daytime worries come back at night in the form of bad dreams. She denied that she had any worries.

At my suggestion, Susan willingly made some drawings in which none of the figures looked happy. She declined my invitation to tell me anything about her pictures. She found the board game Battleship in my large collection of games and toys, and she wanted to play this repeatedly in subsequent play therapy sessions. I came to realize that the implicit theme in the game was sudden death, not unlike that of a car going unpredictably off the road. Therefore, my comments during the play reflected being scared because we never know when a bomb might hit and when our boat would sink. I also expressed concern about what would happen to the people in the boats that sank. I was, of course, referring symbolically to Carl's unexpected, accidental death.

Another time we participated in a squiggle story activity (see "Art Techniques," below), in which Susan's invented story also had themes of sudden death—with danger to a princess, and her eventual rescue by the king. I commented at the end of Susan's story that although the princess had been close to danger, she had decided to create a happy ending by having the father rescue the princess.

After about 5 weeks of therapy, Susan's headaches and nightmares stopped. We had not spoken very much about Carl, and not at all about the specific nature of his death, but Susan had spontaneously chosen play activities with death and danger themes. The therapy connected with this had apparently relieved Susan of some of her anxiety.

Discussion

The play therapy sessions with Susan were primarily nondirective and supportive, with no specific instructions to the child to draw or talk directly about her friend's tragic death. Nonetheless this girl felt safe and understood in the therapy sessions, and she used symbolic play very effectively to convey her fears and anxieties in a disguised form. My role as the therapist was to acknowledge in a general way the frightening feelings about unexpected death, and to remark on the child's choice of a positive story outcome following danger (cognitive mastery). This process seemed to bring cathartic relief to the girl and a sense of mastery through the *symbolism* of her play.

Therapy had begun 2 weeks after the crisis event, and the girl's symptoms initially suggested the probable future development of posttraumatic stress disorder. This is an example of a single-incident trauma that was treated in a timely fashion, using nondirective, supportive crisis intervention therapy that relieved the child's symptoms.

The Case of Sergio, Age 9

Family Information

Sergio grew up in Central America on a farm with his parents and younger sister. Because of gunfights and unrest in their village, Sergio's father left to find work in the United States, intending to send for his family later. After 2 years, Sergio's father made arrangements for his wife to take her two children to Mexico and cross into the United States with the help of a "coyote" (guide) who was supposed to guide the family across the Rio Grande.

The Traumatic Events

Sergio's mother was carrying a basket with clothes on her head and holding her 2-year-old daughter in her arms, while Sergio held his mother's skirts as they started to cross the river. The current was very strong, and the mother lost her footing and fell while Sergio was dragged downstream. He grabbed onto a tree branch, and his mother eventually was able to rescue him. As soon as they managed to get ashore, the "coyote" appeared with a gun and then raped the mother while Sergio watched helplessly in terror. The family then proceeded to a safe house where the father came in a few days to meet them. Sergio did not speak during the entire 2-day period until they were reunited.

Reason for Referral

Approximately 2 months after this series of traumatic experiences, Sergio was enrolled in school, in a bilingual classroom. He did not speak in school; he did not make friends; and when any of his classmates tried to interact with him, Sergio would begin to cry helplessly. In addition, Sergio was having a lot of trouble sleeping at night.

Play Therapy Sessions

The first few sessions consisted of talking, drawing, relaxation exercises, and free-play activities. The Spanish-speaking therapist told Sergio that she was someone who understood children's fears, and that she wanted to help him sleep better and have a better time in school. The therapist initially refrained from presenting Sergio with any toys that might recall memories of his traumatic experiences.

In the fifth session, the therapist decided to introduce a toy bathtub, some small plastic doll figures, and a block of wood floating in the water. She encouraged Sergio to have the figures swim in the water, which he did after pouring some of the water out of the tub. The boy created a happy scene of a family fishing with both the father and mother present.

In the next session, the therapist provided the same toys and asked him to pretend that the water was a river that the family needed to cross. With a lot of ongoing encouragement from the therapist, Sergio eventually recreated his trauma, including the part when he felt as if he were drowning. During this reenactment, Sergio began referring to his own experience (rather than projecting onto the dolls). The therapist's response emphasized how strong he was to have endured such a terrible experience.

In the next session the therapist decided to attempt a "role play" of the mother's rape, using rag dolls. She asked Sergio to show what happened after they crossed the river, and he did so after initially not wanting to do so. The therapist encouraged and reassured Sergio by reminding him that he and his mother were safe now.

In the subsequent two sessions, the therapist encouraged Sergio to act out in play his retaliation fantasies toward the "coyote." This not only validated his anger, but permitted him a way through play to turn the passivity and helplessness he experienced during the traumatic event into active expression of his frustration and anger. Around this time, Sergio's nightmares diminished, and he began to form new relationships with his peers.

Discussion

This boy had suffered a series of traumatic experiences, beginning in his homeland, where his family lived in a dangerous environment surrounded by gunfire. He then endured the stress involved in fleeing from his home without his father and then traveling through a strange country. His own near-drowning, followed by the witnessing of his mother's rape and her subsequent admonition not to talk about it, all resulted in a child who was suffering from multiple (Type II) traumas and met criteria for a diagnosis of PTSD.

The crisis intervention therapy was directive and supportive. After the treatment relationship had developed, the therapist used sensitive persuasion to urge Sergio to reconstruct his experience.

The process of crisis intervention therapy illustrated here demonstrates how to effectively build a relationship with a traumatized child, and then how to gradually help him face his horrible experience, at his own pace. The therapist repeatedly emphasized the boy's strengths and resilience, and the boy gradually began integrating this belief into his own self-concept. The impediments to his normal developmental course were removed through this directive crisis intervention play therapy.

RANGE OF PLAY THERAPY METHODS

Whether the treatment philosophy of the therapist results in a nondirective or a prearranged/directive play therapy approach, the well-trained play therapist must be familiar with a variety of play therapy materials and techniques for working with children in crisis or trauma. Although few offices are equipped with *all* of the play therapy materials listed below and described in case examples in the book, it is important that a range of choices be available to each child. The discussion that follows reviews some of the major play therapy methods, with suggestions about necessary materials. (For a video/DVD demonstration of different play therapy techniques, see Webb, 1994/2006b.)

Art Techniques

The graphic and plastic arts have broad application and appeal to children and adults of all ages. According to Goodman (2002, p. 300), "when a child depicts his/her feelings on paper the therapist then can help the child observe, react, change, correct, and master them." Many therapists invite children to draw both as part of the assessment and as part of the treatment process. Specific types of drawings that a therapist may ask a child to do include the following:

- Draw a person
- Draw a family
- Draw a house
- Draw a tree
- Draw whatever you wish (free-choice drawing)

In the draw-a-person and draw-your-family exercises (DiLeo, 1973; Malchiodi, 1998), the play therapist learns about the child's perceptions of his or her own body, as well as of family relationships. Training in how to assess and use children's drawings in therapy is typically included as part of many play therapy training programs.

Winnicott's (1971) "squiggle technique" is another drawing exercise, which can serve as excellent icebreaker with children who claim they cannot draw. This exercise involves the players' taking turns making pictures out of each other's scribbles. The child subsequently can be asked to select two or three of his or her favorite squiggle drawings in a series and then to make up a story about it. The squiggle story method was used in the case of Susan to help reengage her in treatment when she wanted to terminate.

Modeling clay provides a safe outlet for aggressive feelings, since the clay requires pounding, poking, squeezing, and cutting to achieve the form a child desires. This modality lends itself to family and group play as well as individual therapy, since each member may create an individual project or the group may work on a joint product. See Oaklander (1988) for examples of how to use clay in therapy.

Soft Play-Doh is easier for younger children to handle than is modeling clay, and its greater malleability lends it to being squished between the fingers, thus offering an additional sensory experience. Hurley (1991) illustrated a young girl's anxious use of Plasticine (a material similar to Play-Doh) following her father's suicide by gunshot. The child created several heads that corresponded to the members of her family; she mutilated one head, and then anxiously turned to other play activities. She was not ready to talk about her father's death, but her play conveyed her anxious feelings and allowed the therapist to express some appropriate reactions to the mutilation.

Suggested Art Supplies

- Colored markers; crayons; Cray-Pas
- Paper of different colors; construction paper (full color range)
- Scissors; glue; paste; Scotch tape; stapler
- Water colors; finger paints
- Paper doilies; magazines for cutting out pictures for collages
- Modeling clay (assorted colors); Play-Doh; rolling pins, cookie cutters, and assorted modeling tools

Doll Play

Doll play holds great appeal to preschool children of both sexes and to elementary-school-age girls. Miniature bendable family dolls lend themselves to reenactment of exchanges a child has witnessed in his or her own family. The therapist can learn a great deal from watching and listening to the child's play with the family dolls. Often a preschool child unabashedly names the family dolls to correspond with his or her own family members, and/or selects their hair color and size to match those in his or her own family. Boys may choose to play with toy soldiers, together with trucks and assorted army equipment.

Stuffed animals sometimes take the place of human figures in a child's representational play. Just as in doll play, the child displaces onto the toy animals the feelings and conflicts with which he or she is struggling.

Suggested Supplies for Doll Play

- Bendable 6-inch family doll set (including mother, father, girl, boy, baby, grandmother, grandfather, teenager, woman, and man); these doll sets are available with skin and hair color to correspond to various racial groups
- Set of doll furniture including kitchen, bedroom, and bathroom, or complete playhouse (Fisher-Price)
- Life-size infant doll with bottle and pacifier
- Stuffed animals: monkey, bears, "monster," and so forth
- Army men (miniatures) and assorted war equipment
- "Trouble" dolls (miniature set of seven dolls in a tiny box); therapist's explanation suggests that one doll each day of the week will "magically" work on resolving child's problems during sleep
- Rescue personnel (police officers, firefighters, nurses, and doctors); it is helpful to have some toy police cars and ambulances as well as a toy medical kit
- Fantasy figures: fairy godmother and magic wand, Aladdin and his lamp, a witch, a mermaid, angels, and devils

The principle is to provide the child with an array of figures that will permit the widest possible expression of feelings, conflicts, and reenactments of traumatic events.

Puppet Play

The use of puppets in play therapy, like the use of dolls, rests on the assumption that the child (1) identifies with a doll or puppet, (2) projects his or her own feelings onto the play figure, and (3) displaces his or her conflicts onto the doll or puppet. Both doll and puppet play allow the child and therapist to talk about feelings and thoughts that "belong" to the doll or puppet, with no acknowledgment that he or she has similar feelings. Fantasy also prevails when puppets are used; a puppet that is beaten does not feel real pain, and simulated aggression and killing allow puppet play to go far beyond the limits of human endurance. Another very important feature of puppet (and doll) play is the opportunity to repeat over and over a traumatic experience and its various outcomes. Frey (2006, p. 190) states that because many of the symptoms of trauma are "unconscious, nonverbal, right-brained experiences that cannot be accessed through talk therapy, puppetry methods provide a safe, structured medium to re-enact the trauma so that healing can begin."

Suggested Supplies for Puppet Play

- Family hand puppets (mother, father, boy, girl, etc.)
- Animal hand puppets (an assortment that will permit the expression of a range of emotions—e.g., "neutral" characters such as rabbits or squirrels, and more "aggressive" characters such as lions or alligators)
- Finger puppets (animal or insect)
- Various fantasy (e.g., superheroes) or rescue (police officers, firefighters, nurses, doctors) puppet figures

Although the use of any puppet will vary in the hands of different children, the provision of a wide variety of puppets gives a child choices and permits a range of emotional expressions. I have found that it is helpful to have several puppets of one type of animal or insect, so that children can use them to enact typical family scenes. The combined use of hand (large) and finger (small) puppets of the same category of animal or insect naturally connotes adult and child characters. I used these in play therapy with a 4-year-old child who had severe separation anxiety, pretending that the "mother" bee was going out to get honey to bring back to her "child" bees, who remained home with an "adult" ladybug sitter (Webb, 2003). Insect hand puppets (e.g., ladybugs, spiders, bees, dragonflies, and grasshoppers) provide useful opportunities for children to master through play their fear of insects, and to express in fantasy their "superiority" over these small creatures, which stimulate fear in many of their peers.

Storytelling

From the time of the Bible, stories have captured the human imagination through creative use of fantasy. Stories may be told, read, or watched, depending on the circumstances of the historical moment. All methods involve distancing, identification, and projection. Children, in listening to stories, learn to exercise the power of their imaginations as they envision animal or human characters coping with situations similar in some respects to those in their own everyday lives. Children who watch television may similarly identify with the characters portrayed.

Richard Gardner's (1971) mutual storytelling technique combines the appeal and distancing component of storytelling in a directive play therapy approach that helps a child consider alternative solutions to problem situations. In Gardner's method, the child tells a story to which the therapist responds with an adaptation using "healthier conflict resolution," involving the same story characters and themes as in the child's story. As an additional enticement to the child's participation, Gardner uses audiotape and videotape recordings, which allow the child subsequently to hear or see him- or herself telling the stories.

Storytelling Adaptations

Although Gardner's approach is highly structured, it lends itself to various adaptations. For example, in my work with 4 year-old Michael (Webb, 1999), storytelling was combined with family doll play. I set up a scene in a kitchen using family dolls and miniature dollhouse furniture and, after introducing the doll family, I invited Michael to act out a family interaction by asking "what happens next."

Other adaptations of storytelling involve writing down the child's stories and putting them into a "book," with a cover drawn by the child on construction paper and the pages stapled together. Sometimes this technique is used to record a child's experiences in a natural disaster, such as a tsunami (see Baggerly, Chapter 16, this volume); in other cases, this method has been used to record the life histories of children in foster care and adopted children. The Internet offers several lifebook guides and workbooks to be used by parents, caregivers, or professionals to create a record of the details of an adopted child's or foster child's past life.

A therapist can, when appropriate, encourage a child's written fantasy by suggesting that the child write down his or her stories at home. I often give "blank books" to school-age children as birthday gifts, in order to provide them with an outlet for their written story creations, which they can later bring to the therapy session and share.

Responding to the Child's Story

As with other creative media (i.e., art), the therapist's use of the child's story productions depends on the assessment and treatment goals in each situation. An analysis of the repeated themes in stories or art provides the therapist with diagnostic or added information related to the child's conflicts and feelings. The extent to which the therapist uses the information gained from these indirect techniques depends on the unique factors of each situation. Play therapy is both an art and a science, dependent on the skills and judgment of the therapist. Sometimes the therapist will use the fantasy material with the child in a displaced manner, keeping the disguise; at other times, the therapist may question whether the child notices some resemblance between the fantasy he or she has created and the child's own life. The therapist's training and beliefs about working in a displaced manner versus making interpretations to the child's life inevitably guides the treatment approach. As mentioned previously, therapists working within a cognitive-behavioral framework believe that it is essential to make the *implicit* meaning of a story *explicit* in order for the child to move beyond the crisis or traumatic memory.

Although the techniques for uncovering the child's inner world through art and stories may seem deceptively simple, the therapeutic management and response to the child's revelations depend on a thorough understanding of child development, children's typical responses to stress, and the nature of symbolic communication. Regular supervision is essential for beginning therapists.

Sandplay

Sandplay is a method of play therapy that uses sandboxes and toy miniatures for the purpose of creating scenes in the sand. Usually two sandboxes are available, one with dry sand and the other with damp or wet. The instructions to the child are to make a "world" or a picture of anything he or she wants in the sand, using miniatures the child selects from a variety of choices. After the child does so, the therapist invites the child to tell a story about what has been constructed. This method rests on a knowledge base of Jungian symbols and archetypes; it is believed that objects placed in the sand in therapy represent the individual's unconscious, and that the process of repeated creations over time results in healing (Carey, 2006). The use of sandplay as therapy requires special training and access to a rather extensive supply of materials that make possible this mostly nonverbal therapy process.

Suggested Supplies for Sandplay (Carey, 2006)

- Two sandboxes, 19½" × 28½", with the bottoms painted blue; one box with damp sand and one with dry
- Miniatures of various types, within the following general categories:
  - Animals, birds, fish, insects
  - People of all ages, races, and different occupations
  - Fantasy figures such as superheroes, mermaids, fairies
  - Transportation vehicles of all types
  - Vegetation; fences and bridges; rocks, shells
  - Miscellaneous: wishing well, coffin, beads

Board Games

Fantasy play naturally and gradually recedes in middle childhood as a child becomes more reality-oriented, and organized games begin to take precedence over imaginative play. Interest in games with rules emerges between 7 and 11 years of age, when the child has achieved the level of cognitive development characterized by logical and objective thinking (Piaget, 1962). Game playing requires observance of self-discipline (e.g., waiting for one's turn), cooperation, and obeying rules (Schaefer & Reid, 2001). These ego control functions are beyond the capabilities of most preschool children.

Reid (2001, p. 21) comments that over the past several decades there has been an "explosion in the development of board games specifically for use in counseling and therapy." The value of using board games with school-age children has been cited in the professional literature (Schaefer & Reid, 2001; Webb, 2002). Knowledgeable child therapists view game play as a means to refine diagnosis (by observing how a child plays a game), as an opportunity to enhance ego functions (by helping the child master frustration tolerance and self-control), and as a natural route to improving the child's socialization skills (Schaefer & Reid, 2001).

Board games that hold special appeal for latency-age children include both standard commercial games and games that have been designed specifically for therapy purposes. Examples of the former are Candy Land, Clue, and Connect Four; examples of therapeutic games are The Talking, Feeling, and Doing Game and The Goodbye Game. These and others are listed below, with names of manufacturers.

The concept of winning and losing is implicit in most board games, through accumulation of token "chips" or through progression around a track based on the chance roll of the dice. Children's reactions to winning and losing, and their occasional attempts to change the rules and even to cheat, all become matters for therapeutic discussion. Although most games do not elicit extensive fantasy material from a child, their utility in providing an interactional experience that can be simultaneously enjoyed and analyzed ultimately proves ego-enhancing to the child.

Suggested Board Games

Standard

- Battleship (Milton Bradley): Ages 8 to adult
- Clue (Parker Brothers): No ages specified (probably best for 9 to adult)
- Connect Four (Milton Bradley): Ages 7 and up
- Life (Milton Bradley): Ages 9 to adult
- Sorry (Parker Brothers): Ages 6 to adult
- Operation (Milton Bradley): Ages 6 to adult

Therapeutic

- Stress Strategies (Stress Education Center, Libertyville, IL 60048): Ages 8 to 14
- The Talking, Feeling, and Doing Game (Creative Therapeutics, 155 County Road, Cresskill, NJ 07026): Ages 6 to adult

- The Ungame (P.O. Box 6382, Anaheim, CA 92816) Five versions—"kids" (ages 5–12), teens, family, couples, all ages
- The Storytelling Card Game(Creative Therapeutics, as above): Ages 4–12
- The Goodbye Game (Childswork/Childsplay, Secaucus, NJ 07094): Ages 6 to adult

Other Assorted Play Therapy Techniques

The possibilities for using play therapeutically are limited only by the imagination and creativity of the child and therapist. Insofar as any object may be used symbolically and/or idiosyncratically, it would be impossible to discuss comprehensively or demonstrate, even in a book devoted in its entirety to play therapy, an exhaustive inventory of play therapy techniques. In more than 30 years as a play therapist, I continue to "discover" new activities to use creatively and therapeutically with children.

A Cautionary Note

No therapy office can or should resemble a toy store! This would be overstimulating to most children and countertherapeutic. Many years ago, when renting office space on an hourly basis, I learned that it is possible to carry "the basics" for play therapy in a large satchel. For me, these included paper, markers, scissors, tape, stapler, a few puppets, family dolls, one board game, and a small tape recorder. The selection of materials varied with the ages and interests of the particular child clients who had appointments on a particular day. Children will use their imaginations when allowed to do so, and sometimes simplicity brings benefits that diversity may confuse and obscure.

ROLE OF THE PLAY THERAPIST

In play therapy, as in every form of psychotherapy, the therapist tailors his or her interventions to the needs of each client and the specific treatment goals of each case. Following thoughtful consideration about the implications of his or her attitude and actions on the child, the therapist chooses among the following alternative roles:

1. *Participating*. The therapist plays along with the child, being careful to follow the child's lead and not to jump ahead of the child.
2. *Limiting*. The therapist serves as auxiliary ego, attempting to strengthen the child's own ego functioning by emphasizing rules, encouraging frustration tolerance, and setting limits.
3. *Interpreting*. The therapist gently makes connections between the child's symbolic play and the child's own life. This approach should be used cautiously

and only after a positive treatment relationship has been established. As previously discussed, some therapists do not interpret children's play.

In carrying out these role functions, the play therapist may do the following:

- Observe the child's play.
- Ask the child to describe the play activity.
- Suggest motivations or feelings in the context and metaphor of the play.
- Focus on the child's affect or behavior.
- Participate in the play.
- Set limits when the need arises.

The therapist's role in therapy with a traumatized child should also include the following:

- Establish a supportive therapeutic relationship with the child.
- Teach the child some relaxation methods to help keep anxiety in check.
- Provide toys that will assist the child in recreating the traumatic event.
- After the child feels safe in the therapeutic relationship, encourage a gradual reenactment of the traumatic event through drawing or with toys.
- Move at the child's pace; do not attempt too much in one session.
- Emphasize the child's strength as a survivor.
- Repeat that the traumatic experience was in the *past*.
- Point out that the child is safe in the present.

It is clear from this discussion, and from the many case examples in this book, that the role of the play therapist varies. The therapist always tries to understand the themes and underlying meaning of the child's play, in order to provide communication that validates the child's feelings while also sharing a new vision to help the child through his or her struggles.

TRAINING IN CHILD THERAPY

Just as a child psychiatrist must first demonstrate competence in treating adults before undertaking the board examinations for child psychiatry, I believe that all mental health practitioners seeking to become child therapists should do so only after some solid experience in working with adults. Because of their youthful dependence, therapy with children inevitably includes work with adults, and a family focus is often essential. Child therapists must be able to relate helpfully to parents and other caretakers as well as to children; all too often, treatment failure results from failure to engage parents or caretakers adequately as allies in children's treatment.

Many schools of social work and clinical psychology programs offer elective courses in treatment of children and adolescents, and the internships of such programs often involve work with children and families. Fortunately, regular supervision is a hallmark of these internships, since the challenges and pitfalls of working with child clients, parents, and families demand the careful attention of seasoned practitioners.

Some child therapy training programs in different areas of the United States are listed in the Appendix to this book. A supervised internship is an integral part of these programs, regardless of the number of years of experience or educational background of the trainees. Because of the complexity and special demands of child therapy, supervision is essential for child therapists to help them identify and monitor their countertransference reactions (Webb, 1989).

GROUP AND FAMILY PLAY THERAPY

Many of the same techniques and materials appropriate to play therapy with an individual child can also be used effectively with the child and his or her family and in play therapy groups. Several chapters in this book demonstrate play therapy with children in groups: Nisivoccia and Lynn (Chapter 14) discuss the role of group support in helping children who had witnessed violence in their communities; Schuurman and DeCristofaro (Chapter 9) describe the power of mutual support groups with bereaved children after a parent's death.

By far the majority of chapters in this book describe parent counseling, family therapy, and/or children's group therapy in addition to individual play therapy with the child. When an entire family has experienced a crisis, it is logical to treat the family members together to implement mutual support and enhance their coping skills, in addition to offering individual therapy as indicated. Since children live in a family system, a crisis experienced by one member necessarily affects others. Shelby and Felix (2006) refer to mounting research evidence indicating that parental or caretaker involvement in a child's therapy is a critical part of child trauma treatment.

The fact that this book focuses on play therapy as a method for treating individual children in crisis by no means denies the validity and necessity of utilizing family therapy and group therapy approaches in conjunction with individual play therapy. Readers who want more information regarding family play therapy may consult Schaefer and Carey (1994) and Gil (1994). An overview of children's group play therapy can be found in Sweeney and Homeyer (1999).

PARENT COUNSELING

When a child client lives with one or both parents, the therapist must include them in the treatment plan as a vital component of the child's treatment. Conveying to a parent that he or she will serve as an essential ally of the therapist forms the basis for the parent–therapist alliance. Many child therapists keep this alliance vital by meeting with parents once a month to discuss their children's behavior and reactions, and by establishing a telephone policy inviting parents to notify them of any matters of concern about the children. A therapist respects the confidentiality of a child client by refraining from reporting verbatim comments made by the child in treatment, and by discussing with the parent only general issues related to the child's treatment.

Sometimes it is appropriate for a child's therapist to meet with the parent(s) in the child's presence. This should occur following advanced planning and involvement of the child with regard to the purpose of the meeting. An example of planned parent–child–therapist meetings occurred in the case of the 10-year-old girl with a sleep disturbance, described at the beginning of this chapter. The treatment approach in this case involved individual play therapy with the child, in addition to periodic child–parent–therapist sessions to implement a behavior modification approach as a supplement to the play therapy.

Other approaches to including parents in their child's treatment are conjoint therapy (see Webb, Chapter 18, this volume) or filial therapy (van Fleet, 1994). Therapy with any two family members together is referred to as "conjoint therapy," whereas "filial therapy" (van Fleet, 1994) involves work with the parent(s) alone without the child. The goal of filial therapy is to help the parent(s) interact more effectively with the child; to accomplish this goal, the therapist trains the parent(s) and then supervises parent–child interactions.

In Chapter 6, Neubauer and colleagues describe a different way of including a parent when a child has suffered sexual abuse and witnessed domestic violence. This method begins with parallel individual sessions for the nonoffending parent and the child with the same therapist. After several weeks, when the parent and child have developed trust in the therapist, conjoint sessions take place to address the child's traumatic exposure. The literature addressing therapy with a traumatized child increasingly stresses the importance of including the parent as essential to accomplishing treatment goals for the child.

VERSATILE APPLICATION OF PLAY THERAPY

The play therapy approaches described in this book are generally applicable to children up to 12 or 13 years of age. They can be used in a variety of health, child welfare, educational, and mental health settings by a wide range of play therapists, such as school social workers, child life specialists, early childhood educators, disaster workers, pastoral counselors, pediatric nurses, and child welfare workers, in addition to child therapists from the mental health professions of psychology, clinical social work, and psychiatry. Many of these professionals do not have formal training in play therapy, although they may have knowledge about normal and pathological child development. Our hope is that this volume will spark the interest of these professionals in delving further into the world of childhood and becoming more knowledgeable and comfortable communicating with children through the symbolic language of play, as a means of helping the children overcome the effects of crises and achieve optimal growth.

CONCLUSIONS

Play therapy has a long history of effectiveness in helping children with their conflicts and anxieties. In recent years there has been growing interest in developing methods to help children who have undergone traumatic or crisis experiences. Crisis intervention play therapy (CIPT) uses a combination of directive and nondirective methods to assist the child to regain his or her previous level of functioning. The goal is to help the child recognize that the crisis or trauma occurred in the past. In the context of a supportive therapeutic relationship, the play therapist uses a variety of cognitive, psychotherapeutic, and supportive methods to help the child achieve mastery of his or her distressing or traumatic memories through symbolic and reconstructive play.

Study Questions

1. How can the play therapist explain the value of play therapy to parents who state that "all my child does with you is play"?
2. Discuss the pros and cons of using directive play therapy approaches with children who have been traumatized.
3. What safeguards can and should a play therapist use to avoid retraumatizing a child?
4. Discuss the issue of verbalization in crisis intervention play therapy. How can the play therapist decide whether to make any connections between the child's play and his or her traumatic experiences? Do you believe that it is necessary to make this connection, or do you agree with Lenore Terr that the child is capable of understanding through the symbolism of the play?

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part II

CRISES IN THE FAMILY

Chapter 4

Child Exposure to Parental Violence

CASE OF AMANDA, AGE 4

Maxine Weinreb
Betsy McAlister Groves

This chapter describes the course of treatment for a young child who witnessed her father's physical abuse of her mother. The episodes of actual physical abuse were interspersed with loud arguments and threats of abuse, which had occurred with regularity since the child's birth. This family was seen at the Child Witness to Violence Project at Boston Medical Center, a program that provides developmentally informed trauma-focused counseling for young children and their parents who are exposed to violence. The chapter presents an overview of research and clinical findings about the impact of domestic violence on children, and then focuses on assessment and intervention strategies as demonstrated in the detailed case example.

PREVALENCE OF DOMESTIC VIOLENCE

Although the term, "domestic violence" technically includes any act of interpersonal violence between or among family members, our program defines "domestic violence" as threats of intimidation or violence, or actual acts of sexual or physical violence, between intimate partners. The large majority of victims are women. A national survey (Tjaden & Thoennes, 2000) reveals that 22.1% of women and 7.4% of men experience some form of intimate partner violence in their lifetime. Children are often the hidden victims of domestic violence (Groves, Zuckerman, & Marans, 1993). While the U.S. Department of Justice and state law enforcement officials maintain extensive statistics on adult victims of domestic violence, there are no reliable data on the number of children who are bystanders to this violence. One recent study estimates that as many as 15.5 million children live in dual-parent families in which some form of intimate partner violence occurred at least once in the past year (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). Young children (age 6 and younger) are disproportionately represented in this population (Fantuzzo & Mohr, 1999).

THE IMPACT OF DOMESTIC VIOLENCE ON CHILDREN

As the epidemic of domestic violence has become more publicly recognized, there has been a dramatic increase in research on its effects on family members. Hundreds of studies have focused on the consequences of domestic violence on children. These studies indicate that domestic violence may affect children's emotional and cognitive development, their social functioning, their ability to learn and function in school, their moral development, and their ability to negotiate intimate relationships in adolescence and adulthood (Edelson, 1999; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). It is associated with greater rates of juvenile delinquency, antisocial behavior, substance abuse, and mental illness. A large study of adult patients in California (Felitti et al., 1998) revealed an association between adverse health outcomes and exposure to domestic violence as children.

Young children appear to be particularly vulnerable to the effects of domestic violence. Davidson and Connor (1999) found that if an adult and a child were exposed to the same traumatic event, a child under the age of 11 was three times more likely to develop symptoms associated with posttraumatic stress disorder (PTSD). In a study of children under the age of 4, Scheeringa and Zeanah (1995) found that a child's perceptions of the danger toward his or her caretaker was a strong risk factor for the development of PTSD. Young children's perception of their own safety is closely linked to the perceived safety of their caregivers, and if a caregiver is not safe, the effects on a child may be overwhelming.

A number of studies have documented the overlap between witnessing domestic violence and being a direct victim of child abuse. One study shows a 40% median co-occurrence of domestic violence and child maltreatment in the same family (Appel & Holden, 1998). As domestic violence becomes more chronic in families, the risk that a child will be directly abused grows accordingly. It is not uncommon for older children and adolescents to intervene directly in an attempt to protect their mothers, thereby increasing the risk of direct injury. Infants and toddlers, who may be unable to anticipate danger or get out of harm's way, are also vulnerable to injury.

Children who grow up with domestic violence learn powerful lessons about the use of intimidation and force in relationships. In violent homes, children learn that aggression is a part of intimate relationships, or that it is acceptable to relieve stress by yelling at or threatening another family member. These lessons do not work well for children in other social contexts; they may misinterpret other children's behavior or behave in distrustful and aggressive ways.

Perhaps the greatest distinguishing feature of domestic violence for young children is that it psychologically robs them of both parents. One parent is the terrifying aggressor; the other is the terrified victim. For young children, who depend exclusively on their parents to protect them, there is no refuge. They cannot trust that their caretaking environment will reliably protect them, and this increases their psychological vulnerability (Groves, 2002; Osofsky, 1999).

Although research enumerates many adverse effects of domestic violence on children, several variables may mediate the intensity and severity of a child's response (Pynoos & Eth, 1985). These variables include the chronicity and severity of the domestic violence, the proximity of the child to the violence, and the existence of other risk factors in the child's and family's life (e.g., substance abuse, poverty, mental illness). Children are affected in different ways, and not all children are equally affected. Some children appear to withstand the stresses of domestic violence. Protective factors may include the child's temperament, his or her achievement in school, parental attunement, and a child's relationship with other caring adults. The fact that children are affected in such a range of ways has implications both for practice and policy. Services for children and families affected by domestic violence should offer a range of supports that build on strengths and encourage growth.

CLINICAL FINDINGS ON CHILDREN EXPOSED TO DOMESTIC VIOLENCE

The Child Witness to Violence Project at Boston Medical Center, a clinical mental health intervention program for children age 8 and younger who have been exposed to violence, was founded in direct response to the high prevalence of young children exposed to violence in Boston (Taylor, Harik, Zuckerman, & Groves, 1994). The majority of children referred to the program are exposed to domestic violence.

A retrospective analysis of clinical information from 149 children under the age of 7 seen in the Child Witness to Violence Project gives an interesting profile of young children whose parents decide to seek help for exposure to domestic violence. The majority (73%) of referred children were boys. Nearly two-thirds of the children had been exposed to violence chronically since birth, according to parent report. The most common symptoms mentioned by parents were increased aggression, impulsivity, temper tantrums, sleep dysregulation, and separation anxiety. In addition, parents mentioned preoccupation with the violent event, as seen in play, verbalizations, and avoidance/withdrawal.

In our clinical work with young children, we have learned about the importance of understanding the violence from the child's perspective. Children make unique meanings out of events in their lives, which are in part based on age, developmental stage, and prior life experiences. Furthermore, children's understandings of events may differ significantly from the adults' appraisals of the same event. An essential component of successful therapeutic intervention with traumatized children requires understanding their subjective experiences of trauma, assisting them with distortions they may have, and helping the caretaking adults better understand the children's perspective.

Our model of intervention draws heavily from a treatment model developed by Alicia Lieberman and Patricia Van Horn (Lieberman & Van Horn, 2005) at the Child Trauma Research Project at the San Francisco General Hospital. The intervention model, called "child–parent psychotherapy" (CPP), has demonstrated its effectiveness in reducing symptoms and improving functioning of both children and their mothers who are involved with the treatment. This intervention has been recognized as an effective and evidence-based intervention by the National Child Traumatic Stress Network and is being disseminated to sites across the country.

CPP recognizes the centrality of the child's relationship with a parent in the early years; it targets the parent–child relationship, rather than only the individual child or only the parent. CPP builds on the premise that the attachment system is the main organizer of the child's response to safety and danger in the first 5 years of life, and that emotional or behavioral problems can best be addressed within the context of the attachment relationship. The intervention seeks to strengthen the parent–child relationship, recognizing that this relationship is the most important protection a child can have.

CPP focuses on the development of both the parent and the child. Infants, toddlers, preschoolers, and school-age children are in a rapidly developing process of growth and learning. The impact of trauma on their lives will be dependent on their ages and developmental stages. CPP allows developmental issues to guide the treatment. This model enables parents and children to increase their understanding of the other's perspective and to build stronger mutual relationships.

PRINCIPLES OF INTERVENTION WITH CHILDREN AFFECTED BY DOMESTIC VIOLENCE

The Child Witness to Violence Project treats children and mothers affected by domestic violence in flexible combinations of individual and parent–child meetings. The specific arrangement of sessions may depend on the age of the child, the presentation of the mother, the topics to be discussed, and the preferences of the child and mother. Regardless of the configuration of the sessions, the parent is essential to the treatment and is actively involved.

The initial phase of the assessment includes an evaluation of each family's safety and immediate needs. In this phase, families may need referrals for legal assistance, housing, or other concrete services. This case management/advocacy is an essential component of the intervention. If families are not safe, or if the violence is ongoing, trauma-focused work cannot begin. Once these initial issues have been dealt with, the assessment focuses on the child's symptoms that are interfering with daily functioning, the parent's concerns about the child, the child's experience with the violent event, the child's understanding of these events, the parent's emotional strengths and vulnerabilities, and the child's strengths.

The goals of treatment include relieving symptoms that interfere with functioning; increasing skills of parents and children at recognizing and regulating affective states; creating a trauma narrative and shared understanding of the meaning of the trauma; increasing the child's and parent's ability to understand the perspective of the other; and strengthening the child–parent relationship.

Obviously, when treating a young child exposed to violence, the clinician needs to consider these principles and issues. The following case example, which was formulated from a composite of several families with whom we worked, strives to translate those principles and issues into therapeutic practice.

CASE EXAMPLE AND APPLICATIONS OF THE PRINCIPLES AND METHODS

Family Information

Amanda (age 4 years, 3 months) was referred by a battered-women's advocate from a nearby health center, where her mother had sought help for the increasing tension, violence, and fear in the household. She lived with her mother, Miriam, and her 2-year-old sister, Stephanie. Amanda's father, Yosef, had moved out of their house 3 months ago after being arrested for domestic violence.

Both of Amanda's parents were professionals who were trained as engineers. Miriam was born in the United States. Yosef was Israeli, but had lived in the United States for 6 years. When Miriam met Yosef, she was astounded by his history of multiple violent and politically related deaths of family members. The marriage appeared to be one of political sympathy on her part, and it deteriorated quickly. Miriam and Yosef were both Jewish, but Miriam did not practice the religion. However, she did identify with some of the cultural values of Judaism, including a commitment to altruism. Yosef adhered much more closely to the dictates of the religion. He believed that it is a mother's responsibility to keep the family together and to do as her husband commands. Miriam did not embrace that piece of the culture and felt that Yosef distorted the meaning of such cultural beliefs. Yosef was reported to be very controlling. He made all family decisions unilaterally, withheld his share of financial resources, screamed insults at his wife during unprovoked rageful outbursts, coerced sexual activity, and even unabashedly brought home a mistress to live with them for a while.

On the day of Amanda's fourth birthday, the family rode down in the small elevator from the ninth floor of their apartment building, headed for Amanda's birthday party at a children's restaurant. They were loaded down with presents, balloons, and other party paraphernalia. Even before the elevator door closed, Yosef and Miriam began to argue, and the quarrel immediately escalated to physical assault when Yosef shoved Miriam against the back of the elevator and held her head there. The attack startled Amanda and caused her to let go of the balloon she had been holding. The balloon popped, and, given the small space in which this all occurred, the reverberation from it was thunderous. Amanda began to tremble and sob uncontrollably. Her mother tried to soothe her when they reached the lobby, but Amanda could not be comforted and pleaded for another balloon.

In a subsequent incident, Yosef shoved Miriam's head against the refrigerator, and she momentarily lost consciousness. She then called the police, who arrested Yosef, and he spent the weekend in jail. After Miriam procured a restraining order, Yosef moved out. Neither child was in the house at the time of the second incident, and therefore neither witnessed it. However, when the children arrived home, they noticed the bruise on Miriam's forehead. Miriam explained, "Daddy hurt my head. I made Daddy leave because he hit me." Stephanie went off to play after the explanation, but Amanda began to cry. Miriam comforted her and reported that Amanda recovered fairly quickly.

Miriam decided to file for divorce. Yosef retained a lawyer and was granted visitation with the children that included an 8-hour daytime visit every other week. Miriam was unhappy about the visitation arrangement, but decided to wait and deal with the question of visitation at the time of divorce. There was also a pending assault charge against Yosef, resulting in Miriam's involvement in two different courts.

Presenting Problem

Miriam sought treatment for Amanda approximately 3 months after Yosef left their home. She was desperately worried about her daughter, stating that she "would not stop talking about the balloon that popped." She noted that Amanda was extremely frightened, and that after the balloon incident she developed sleep difficulties, including nightmares and problems falling asleep. Miriam added that Amanda was having difficulty making the transition to day care and whined continually when any family routines were altered. She also described her as occasionally "pushy" when playing with Stephanie. Finally, Amanda talked regularly about the departure of her father.

Parent Interview

Given that young children's development occurs in relationship to their caregivers (Lieberman & Van Horn, 2005) working with the child in the context of the family is critical. In fact, caregivers are often the central therapeutic agents for change. However, when caregivers are themselves traumatized as a result of domestic violence (as was Miriam), it is not uncommon for them to have difficulty being emotionally available, sensitive, and responsive to their children. Therefore, when a clinician is interviewing a battered mother, it is important to consider her symptoms, her ability to maintain an empathic relationship with her child (which may become ruptured as a result of the trauma), her skill in recognizing danger or stress, and her capacity to support the child. This extremely sensitive assessment requires the clinician not only to be familiar with the effects of violence on children and their parents, but to be highly responsive to the mother from the very first contact.

Goals of Parent Interview

- Assess safety and stabilization of Miriam and her children.
- Obtain Amanda's developmental history.
- Obtain a detailed history of the traumatic exposure.
- Identify current symptoms in Miriam, Amanda, and the family system.
- Learn about Miriam's reactions to Amanda's symptoms.
- Understand the quality of the attachment relationship between Miriam and Amanda, as well as Miriam's ability to support Amanda.
- Obtain a history of Miriam's psychological functioning.
- Identify Amanda's and the family's strengths.
- Provide psychoeducation, including information about symptoms of trauma, children's ambivalent feelings about their abusing parent, the way young children think and understand events, and normalizing of child and parent reactions.
- Offer hope that things will improve.

In the initial two interviews with Miriam, the clinician (Maxine Weinreb, the "I" in what follows) gathered the family information presented above. Miriam presented as a woman with intense anxiety and symptoms of hyperarousal. She stated that she had been "a worrier" since childhood, but she had never previously felt so overwhelmed. She expressed fear of her husband and was terrified that each time he called, he would try to persuade her to take him back. Miriam reported that Yosef was calling the house to speak with the children, and that she couldn't help trembling and crying when these calls occurred. She was especially worried that he would try to kidnap the children, but she felt helpless to prevent it.

It was clear that Miriam was very concerned about and sensitive to the reactions of her children. She talked in great length about the guilt and shame she was experiencing, due to her belief that she was unable to protect her children from the rages of her husband. She worried that her children, especially Amanda, would be damaged forever, and that Amanda would never forgive Miriam. As she talked about it, she began to quiver and cry. Miriam and I went on to explore her feelings at length: She felt ashamed that she had stayed with Yosef for as long as she had, experienced herself as a failure in the relationship, and doubted her skill as a parent. I acknowledged and validated Miriam's strong feelings, and added that such feelings are commonly held when there has been a traumatic experience such as that which she and her children had endured. We agreed to talk more about her feelings in subsequent sessions. I also offered concrete information about the effects of trauma on children and explained that Amanda's symptoms were "normal responses to abnormal events." I reassured Miriam that her thoughtful decision to seek therapy for Amanda was a significant way to help her; I added that I expected that, like most children who get therapeutic assistance after such events, Amanda would progress well.

Preliminary Treatment Goals for Miriam

- Create an alliance/partnership with Miriam to help Amanda begin to heal from her experiences.
- Continue psychoeducation about trauma and the role of therapy.
- Help lessen Miriam's guilt, shame, and anxiety about her daughter's difficulties.
- Restore Miriam's self-esteem and confidence as a parent.
- Refer Miriam for individual trauma-focused therapy and for assessment of anxiety.
- Support Miriam's relationship with her domestic violence advocate to assist with safety planning.

Process of Play Therapy

First Session

Amanda came into the playroom with her mother, but separated from her shortly after the session began. She presented as a meticulous, well-organized, verbal, and even precocious child who moved carefully from one toy to the other as she explored the room. She talked spontaneously to me about what appealed to her in the room and invited me to draw some rainbow pictures with her. When I asked, "Do you know why your mommy has brought you here to talk to me?", she replied vehemently, "Because my mommy and daddy were fighting, and my dad doesn't live at our house any more." When I asked if she knew why her dad couldn't live with them any more, she said, "Because he hit my mommy, and that is wrong." She added, "My daddy scares me. He makes monster noises." When asked if she might care to draw a picture about what she was telling me, she drew a tidy picture of her family standing in a line holding hands. She said about it sadly, "I miss Daddy." This sort of ambivalent feeling about a perpetrating parent is common among children exposed to marital violence. However, since children at Amanda's developmental level find it cognitively difficult to integrate two conflicting feelings at one time, I felt it especially important to clarify and reflect those feelings. It also gave me an opportunity to explain my role in a context that was concrete:

THERAPIST: Sometimes you feel afraid of Daddy. Sometimes you miss seeing him. Sometimes you feel both things all together.

AMANDA: Yes, I do.

T: I bet that can be confusing. It can make kids worry, too. Lots of children who come here have worries like that, and it is my job to help with those worries.

A: Oh. (*Falls silent for a while.*)

A: I do have worries. (*Does not elaborate further. I understand this as her way of managing very strong feelings and do not pursue it.*)

T: We can talk or play about worries if you decide you want to.

Shortly after that dialogue, Amanda shifted her play to the rubber animals—orchestrating a complicated and highly organized battle among four of the animals, in which each alternated between taking the role of a "bad" and a "good" animal. When I commented that it seemed difficult to figure out who was good and who was bad, she nodded her head vigorously. I replied, "Maybe you and I can try to figure it out together some time."

The session ended with Amanda directing me to read *Goldilocks and the Three Bears* to her. She giggled enthusiastically at the end when Goldilocks ran off. In the interest of forming a relationship, I chose simply to narrate the story and not to make any guesses or interpretations about the meaning of the story to Amanda.

Preliminary Assessment of Amanda

Amanda presented as a creative child who was able to play spontaneously. Her play was marked by orderliness, precision, an ability to sustain tasks, and considerable verbal content. In fact, she had no trouble in responding verbally to my questions. She expressed appropriate affect in talking about her experience and indirectly described her ambivalence about not living with her father any more. She expressed some confusion about the separation in her family, and I wondered about the possibility that Amanda was absorbing some of the anxiety that Miriam felt regarding Yosef. Her intelligence, memory, and other cognitive abilities appeared to be above average, and she was able to express feelings through play and art. She used adults well as resources and appeared to be very ready for a therapeutic experience.

Treatment Goals for Amanda

- Establish a safe therapeutic environment.
- Relieve Amanda's symptoms, including difficulties with transitions and sleep.
- Help Amanda to name, identify, release, and regulate strong feelings.
- Restore Amanda's previous level of functioning in development, daily activities, and adaptive coping.
- Restore her strong attachment with her mother, and help her continue to use adults as resources.

Second Session

The next session began with Amanda running excitedly into the playroom and heading straight for the animals. She orchestrated the same battle as in the first session, where the good and bad animals fought. When I asked if anyone could help, she said sadly, "No." I pursued this and asked if the animals would like someone to help, and Amanda said, "Yes, later." This strength in wanting help should serve Amanda well; I understood her current wish to delay the help as her need to play out the conflict until she could resolve or at least make some sense of it herself. Soon after, she invited me to join her in the play and instructed me to tell the "bad" animals to go away. I repeated what Amanda directed me to say, and added strongly, "We can't have bad animals here." Amanda's eyes gleamed with excitement and her body became more relaxed after my pronouncement. She then added, "My daddy hit my mommy. He is bad. He can't live with us."

When I asked how she felt about her daddy and the hitting, Amanda suggested coyly that I "talk to Mommy" about that question. I was unsure of the significance of Amanda's proposal, but hypothesized that she was attempting to make meaning of the events, and needed and wanted the help of her mother to do so. It might also be that she was keenly aware of her mother's anxiety and was unsure how to respond. I saw this as an opportunity to strengthen the mother–daughter attachment, and asked if Amanda might like it if she, her mother, and I all talked about what happened when Daddy hurt Mommy. She nodded enthusiastically and, at the end of the session, again asked me to read *Goldilocks* to her.

After the session, I scheduled and subsequently had a meeting with Miriam. I first checked in with her about her current feelings, functioning, and anxiety. Although still highly anxious, Miriam was committed to Amanda's healing, and directed the conversation to Amanda and how she was progressing in therapy. I then told her that I thought Amanda might want to talk with her about what had happened in their family. We discussed what Miriam thought about that idea, how such a conversation might play out and affect Miriam, and whether Miriam felt that it was something she could mobilize herself to do without undue anxiety. Miriam said that she agreed that Amanda needed to talk about it, but that she was not sure if she (Miriam) could do it well without some assistance from me. In an effort to restore Miriam's feelings of confidence as a parent, I reassured her that her instincts and skills as a parent were strong, but that I would unquestionably be there to help if it became necessary.

Third Session

Both Miriam and Amanda came into the playroom for the third session. After some talk about Amanda's new shoes, I directed the meeting back to Amanda's suggestion from the prior session that I talk to her mother about Amanda's feelings.

Content of Session	*Rationale/Analysis*
THERAPIST: Amanda, remember you told me to talk to Mommy about your feelings about Daddy hitting?	
AMANDA: Yes. He hit.	
T: Yes. Mommy is here now, so we can talk. Is that OK?	I am not entirely sure where this will go, but I believe that any retelling of the narrative must be done with sensitivity and with the permission of both child and parent.
A: Yup.	
T: Miriam, do you think that is a good idea to talk about this?	
MIRIAM: (*With anxiety in her voice*) Yes, I want to talk to Amanda about it, even though it might be hard. [This statement is a version of what we had rehearsed in our prior meeting.]	I know this isn't easy for Miriam, and I am touched by her resolve to talk about what is likely to be very difficult material.
T: OK. Miriam, Amanda told me that her daddy hit you and that I should ask you how she feels about it. You told me that he hit you too, Miriam, and I know you also have feelings about it.	My goal in the next few interchanges is to support and label the affective experiences of both.
M: (*Somewhat teary*) I feel sad, and I think Amanda feels sad too.	
A: No, Mommy. Tell her about the elevator.	
M: Daddy hit me in the elevator.	
A: It broke my balloon. I was ascared [*sic*].	It appears that Amanda has associated the loud noise of the balloon with the violence she witnessed. Since the focus is on the shared telling, I decide not to address the cognitive distortion at that time.
M: (*Looks to therapist for help.*)	
T: It seems you were both afraid. Anyone would be afraid.	How frightening! I am so moved by their terrible experience and what they endured that my eyes well up with tears. I understand Miriam's anxiety. I want to go to "safer ground," too, but I know how important it is for them to talk about what happened, and I can't let my feelings get in their way. Somehow I am able to get back on track.
M: Yes, he hit me. He can't do that to me or you or Stephanie. I made him leave.	
A: He shouldn't hit.	

T: Right. Mommy is trying to keep you, Stephanie, and Mommy safe.	Like all children, Amanda relies on her mother to tell her what is safe and what is dangerous. Witnessing domestic violence potentially compromises the attachment system and a child's perceptions of caregivers. When I emphasize that Miriam is trying to keep them all safe, the goal is to restore and strengthen the attachment relationship.

Amanda grinned broadly and proceeded to the dollhouse, where her play shifted from her usual use of animal figures to human figures. She labeled the people in the house as "Mommy," "Daddy," and "Sister," and asked for some markers. She directed her mother to write a letter to her father, which she would dictate. Amanda then began to dictate a letter as follows: "You were bad. You were mean to Mommy. You hit Mommy. You were bad. You can't come back to our house ever." Although Miriam was obviously distressed, the joint writing of the letter seemed to be therapeutic for both Miriam and Amanda, even though the letter was not sent. At the end of the session, Amanda asked me once again to read *Goldilocks*.

Middle Sessions

The middle sessions consisted of a combination of individual and dyadic (parent–child) meetings. In the next several sessions with Amanda, she continued to play the "animal fighting game" and the "writing letters game." I recognized this sort of repetitive play as common in a child exposed to violence and other trauma; the experience is relived in order to make sense of it (Terr, 1990). It might be that the violence perpetrated by Amanda's father had disrupted her view of her father as a protector, and that she needed to tell him so. She used the play to express both her external and internal feelings, to clarify her role in relationship to her father, and to lessen her anxiety about visits with him. Each session continued to end with me reading *Goldilocks and the Three Bears* and Amanda shrieking with delight each time Goldilocks ran away. This story seemed to help her organize her experience as predictable and gave her the comfort of routine.

In meeting with Miriam, she indicated that she was continuing to meet with her domestic violence advocate to help her with safety planning. The strategies discussed in those sessions decreased Miriam's anxiety about her own safety, but she continued to agonize about the children's well-being when they visited with Yosef. She also followed through on the referral for her own individual therapy. Miriam reported that she was pleased with that therapist's help, including a referral for a medication evaluation that resulted in Miriam's being prescribed an effective antianxiety drug. She reported that Amanda also seemed calmer, and that she talked much less frequently about the "popping balloon."

In meetings with Miriam and Amanda together, they continued to play together with mutual enjoyment.

Eighth Session

Near the end of the fourth month of treatment, Amanda came to the session obviously distressed and preoccupied. She snuggled up next to me and vigorously sucked her thumb.

Content of Session	*Rationale/Analysis*
THERAPIST: You seem worried today.	I am attempting to identify feelings and affect.
AMANDA: No. I am bad.	
T: You feel bad?	
A: No. I am bad.	
T: Bad? Can you tell me about it?	
A: I hit Stephanie [her younger sister] hard. She took my Barbie. She took My Little Pony.	
T: You must have been angry at Stephanie.	I think I get it—it seems obvious.
A: (*Annoyed*) Yes. I hit my sister. (*Amanda then begins to play the game where the animals fight repeatedly and then get banished under the table.)*	Now I have it! I had previously understood the banishment play as Amanda's way of processing her parents' violent separation. With Amanda in the role of aggressor, I suddenly understand that there are multiple meanings, thoughts, and feelings associated with the "animal fighting game."
T: Amanda, I wonder if you are worried that your mommy might send you away.	When a child is exposed to violence as Amanda was, it is common for the child's sense of self and trust in caregivers to become flooded with fear and mistrust—responses that are in conflict with age-appropriate striving for closeness. I put these feelings in as simple language as I can.
C: (*Suddenly crying*): Yes. I hit.	
T: You are worried that Mommy thinks you are bad and will send you away for hitting, just like she did Daddy.	The trauma that Amanda experienced, and her developmental understanding of events, are likely to have disrupted her view of her attachment figures as protectors and havens of safety.
A: (*Sobbing*) Yes. I was bad. I hit.	

T: I know you are worried, and that is OK, but you don't have to worry. I know Mommy loves you and won't send you away, and here is why. Your daddy is a grownup. He knows the rules. Children are just learning the rules, and Mommy knows that.	A young child's sense of self evolves in the context of relationships with the primary caregivers, and enhancing the quality of those relationships is the most effective vehicle for promoting the child's healthy development. By reassuring Amanda that her mother won't banish her, I am attempting to build on their relationship.
A: Maybe she will. T: Maybe we need to talk to Mommy about this. What do you think? A: (*Whimpering*) Yes.	It isn't enough to have this reassurance come from me. Amanda needs direct reassurance from her primary attachment figure—her mother.
T: Should I do that, or should we ask her to come in and play with us and talk about this? A: OK.	Given that children exposed to violence may have an intense fear of losing both parents, my plan is to help alleviate Amanda's fear that she could lose Miriam. I am acutely aware that I am taking the chance that Miriam may not be emotionally available at this time. I am somewhat anxious about whether this suggestion may backfire and be more upsetting to Amanda.
T: OK, we talk to her? All of us, or just me and mommy? A: All. (*Amanda and I go out to the waiting room to see Miriam and invite her to the therapy room.*)	I am aware that young children like Amanda may get confused by long questions, and that as a result they sometimes only respond to the end of questions. I attempt to clarify to get a clearer understanding of what she wants and needs.
T: Miriam, Amanda has a question to ask you. It is something about which you are the expert. Amanda, do you want to ask Mommy, or shall I? A: (*Blurts out*) Mommy, are you going to tell me not to live at our house any more?	I attempt *not* to take over, but to give Miriam and Amanda the opportunity to understand each other.
Miriam: (*Visibly upset, starts to shake*) What, Amanda? Did your father tell you that? What did he tell you (*angrily*)? (*Amanda begins to cry.*)	I think Miriam's strong reaction to Amanda's question is related to her own fears and anxieties about her husband.
T: Amanda, I think your mommy is getting very worried and mad about	I feel it is important to help mother and daughter understand each other's

your daddy. She might be remembering when he did scary things to her and you. Miriam, I know you are worried, but that isn't quite what Amanda wants to tell you. Amanda said she hit her sister, and she is afraid you won't let her live at your house any more, because she did a bad thing just like her father.	behavior and perspective, and to support and label the affective experiences of both members of the dyad.
M: (*To Amanda, crying*) Oh, honey, I would never send you away. You shouldn't hit your sister, but kids make mistakes. (*Amanda runs to her mother and snuggles in her arms.*)	After witnessing this warm encounter, I wish that I had provided an intervention earlier to remind Amanda and Miriam that safe and supportive physical contact can be a welcome source of comfort and not a source of danger or fear.
T: When bad things happen, everyone gets confused and scared. It is good to talk about it and figure it out together.	I attempt to provide information about the effects of exposure to violence. I also hope they both get the message that talking about their shared experience can help them make meaning of it.

Final Sessions

Following the sessions presented above, Amanda continued treatment for 3 more months. Throughout the process, I was alert to further disruptions in the parent–child attachment, the cognitive distortions in Amanda's understanding of the events, and Amanda's need to tell all or part of the trauma story. The bond between Amanda and Miriam continued to strengthen, and Amanda found it easier to separate from her at school and to sleep through the night. Amanda did remain somewhat hypervigilant to loud noises, but with my help, she was able to label them as "surprise noises" that couldn't hurt her.

CONCLUDING COMMENTS

For as long as we have done this work (over 15 years), and as seasoned as we are in clinical intervention with children exposed to violence, it is always difficult to acknowledge that some of our youngest children and their family members are subjected to such frightening and even life-threatening experiences. There are times, especially when children and/or family members tell us all or part of their trauma stories, that we are extraordinarily saddened and overwhelmed. We are particularly lucky to have an "open-door" policy at the Child Witness to Violence Project, so that when we have a difficult session, there is usually another staff member with whom we can process the session fairly immediately. This helps us deal with our own feelings, explore our own countertransference, and/or prevent our vicarious traumatization. Certainly it was this support that helped me deal with the strong feelings elicited by this darling little girl, Amanda, and her heroic mother, Miriam. We recommend strongly that this kind of peer support be available to all clinicians who work with traumatized children and their families.

As we think about the work with Amanda, her presentation was similar to many children exposed to violence: She experienced symptoms of sleep dysregulation, had difficulty with transitions, demonstrated some mildly aggressive behavior, and was troubled by separation anxiety. She also had ambivalent feelings about her father and was unsure that the world was safe or that adults could be reliable protectors. With relatively short-term play therapy, Amanda was able to express her feelings and worries. Her symptoms decreased, and she was able to recover a sense of mastery (i.e., her separation issues decreased to those that were age-appropriate) and to make meaning of her experiences through play. However, had she not been progressing normally and/or had other family risk factors existed (e.g., parental substance abuse, mental illness, or poverty) prior to the escalation of her father's violence, it is unlikely that she would have recovered so quickly. In fact, many children have multiple traumatic events that affect their safety and stability and impair them in multiple ways (Cook, Blaustein, Spinazzola, & van der Kolk, 2003), so that therapy with them requires a much longer intervention.

Miriam's participation was a critical factor in Amanda's recovery from the trauma of exposure to violence. As Miriam began her own recovery, she was able to provide more adaptive, calm, and nurturing interchanges with Amanda. As Amanda played out her fears and fantasies related to the violence she had witnessed, made meaning of the events in her life, and came to see her mother as a strong protector, she was able to begin to heal from the traumatic experiences. She was also able to integrate her feelings about her father and subsequently focus on the appropriate developmental tasks of childhood. On the other hand, as Amanda grows and her developmental understanding of the traumatic events in her life changes, it is possible that she will need to come back to revisit her feelings about the events (James, 1989). For example, Amanda was exquisitely sensitive to her mother's anxiety about the visitation arrangement; if these arrangements change, new and intense emotional issues are apt to emerge for both Miriam and Amanda and will need to be addressed. In addition, if there continues to be court-ordered visitation, it might be clinically appropriate to involve Yosef in some individual sessions centering around parental guidance.

Given Miriam's personal strengths and her restored strong attachment to Amanda, we are confident that Miriam will manage well and will contact us if she needs further assistance. We also acknowledge that it is Miriam who is in charge of her family, but we cannot help hoping that she takes up the invitation to call from time to time and update us on how things are going. This family touched us deeply.

Study Questions

1. Discuss the effects of exposure to violence on a child's functioning.
2. The therapist notes that involving the parent is critical in work with a young child. What are the advantages and disadvantages of bringing a parent into the session?
3. There are varied opinions about whether it is essential in treatment to have the child retell or reenact the trauma. Discuss whether or not this is a necessary treatment goal.
4. If Amanda had not wanted to talk to her mother about her feelings that she would be abandoned by her mother for hitting her sister, how could the therapist have handled it?
5. What do you think was the meaning of Amanda's need to hear the story of *Goldilocks* at the end of each session?
6. What do you think are the clinical reasons for the "writing letters game," and how else might it have been handled?
7. Discuss the role of culture in this case and the issues surrounding it that the therapist might have explored. How would learning more about the cultural outlook and traditions of this family have helped the therapist learn more about the family's child-rearing values and practice? What countertransference issues may have been present?

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Chapter 5

Parental Abuse and Subsequent Foster Home Placement

Marilyn B. Benoit

In the United States, the term "child abuse" refers to a range of child maltreatment issues that include physical and sexual abuse, emotional or psychological abuse, and child neglect. Parents found guilty of child abuse and/or neglect may lose temporary or permanent custody of their child(ren) to the child welfare system in the state in which they live. In this chapter, the generic term "parental abuse" refers to both abuse and neglect by parents; also, the term "parents" usually refers to biological parents, but may also include adoptive parents, stepparents, or legal guardians. The U.S. Congress recently reauthorized the Child Abuse Prevention and Treatment Act (CAPTA; P.L. 93-247), first legislated in 1974. The CAPTA federal definition of "child abuse and neglect" is "any recent act or failure to act on the part of the parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk or serious harm to a child under the age of eighteen." Individual states may have statutes that modify the federal definition, but the general principle applies in all states.

According to the Child Welfare League of America (CWLA, 2006), states do differ in the level of findings concerning child abuse and neglect that would trigger an out-of-home placement of a child into the foster care system. The CWLA's 2004 national data analysis of state-by-state "level of evidence" required to substantiate a report shows that states utilize several evidentiary levels: "preponderance of evidence" (the highest legal standard), "credible evidence," "reasonable evidence," "probable cause," and *other* standards. (For a comprehensive listing of each state's standards, see CWLA, 2006.)

The Adoption and Safe Families Act (ASFA; P.L. 105-89) has played an important role in the length of out-of-home placement of children, as well as in permanency planning. ASFA mandates limited periods (12–14 months) for achieving permanency of child placement. While this law has resulted in accelerated efforts to place children permanently, it has not been without some problems and controversy. One of the areas of concern has been the high prevalence of substance abuse among the birth parents of children who have been placed in state custody (Smith, Elstein, & Klain, 2005). Substance abuse tends to be chronic and relapsing, and may not necessarily match the ASFA timelines imposed on such parents.

CHILD MALTREATMENT DATA

Although there has been some decline in the numbers of children going into foster care over the past several years, it has not been significant, and the overall nationwide number has remained relatively stable at about half a million children in foster care each year. The Office of Child Abuse and Neglect (McDonald & Associates, 2006) reported that in 2004 more than 872,000 children were victimized, with 62.4% of children being referred primarily for neglect issues. Another 17.5% were victims of physical abuse; 9.7% were victims of sexual abuse, and 7.0% were considered victims of psychological abuse. As has been consistent over decades, parents continue to account for the largest percentage (83.9%) of perpetrators of abuse of children. In 2004 over 3 million cases were investigated by child protective services (CPS) in the United States and its territories; this represented an increase of 32.4% since 1990.

Parental abuse in all its forms occurs across the socioeconomic spectrum. However, the preponderance of cases coming to the attention of the child welfare system are referred from families of lower socioeconomic status (SES). Because minority status and low SES covary in the United States, Native Americans (American Indians and Alaska Natives) and African Americans are disproportionately highly represented in the child victims reported to the child welfare system: 15.5 per 1,000 and 19.9 per 1,000 respectively, compared to 10.7 per 1,000 for European Americans, and 10.4 per 1,000 for Hispanics. Asians had the lowest rate of reported child victimization, at 2.9 per 1,000 (ACF, 2006). However, I question whether the data from some immigrant populations accurately reflect the prevalence of abuse in their communities, since cultural and language barriers may be obstacles to accurate reporting.

CRITERIA FOR REMOVAL AND PLACEMENT DECISIONS

There is no national standard for specific criteria to determine which children are removed from their parental homes. One study (Britner & Mossler, 2002) reported that it was primarily professional group membership that seemed to determine how this decision was made. In 2003, (Toni, 2006) 15.1% of referred cases resulted in removal from the home. Only 22.8% received family preservation therapeutic support as an intervention. This means that 62% of referred cases resulted in no reportable action.

It is generally agreed that removal of a child from the parental home is primarily a *safety response*. According to Action for Child Protection (2004), "The purpose of safety intervention is to control or manage dangerous behaviors, situations, perceptions, emotions and intentions that threaten a child's safety rather than changing the causes of such conditions" (p. 2). In its training guide, the California Social Work Education Center (2001) emphasizes that in deciding on placement, workers should adhere to the principle "Do no harm." In order to do so, it is critical that the first-responder worker(s) should do a risk assessment to determine the safety risk posed to a child within the parental home. Such an assessment should be based on verifiable facts, and if indeed the child is endangered and needs to be removed, the placement itself should not present any safety risks to the child. Since the goal should be to minimize the trauma to the child, all conceivable efforts should be made to determine whether the child can remain within the parental domain if his or her safety is ensured with the provision of support services to the child and family.

While child welfare experts often discuss the role of the community in ensuring child safety, and embrace the concept "It takes a village to raise a child," this concept is not one that has really taken hold around the country. Therefore, the choice of having the community provide safety alternatives for placement of maltreated children is not one that is commonly available to child welfare workers. Actually, the decision-making process about placement is inconsistent across states and even within states. This may be due in part to inadequate training of first responders, many of whom may be new to child welfare work. In a field that is blighted by too frequent worker burnout and turnover, implementing standardized training and protocols for assessment and removal remains challenging. Additionally, because of a chronic shortage of foster homes, placement decisions in crisis situations often lack the thoughtful process that should be required in such cases. Reports of children being kept at agencies overnight are not uncommon, and emergency placements can easily "morph" into long-term placements.

The American Academy of Child and Adolescent Psychiatry (AACAP) and the CWLA have joined with leaders of other national organizations to form a coalition to address the issue of the mental health of children in the foster care system. In that coalition's *First Responders* document (AACAP & CWLA, 2004), the focus is on assessment of the child's mental status and the necessity of making a determination of the need for urgent or emergency mental health services for any child who is being removed from the parental home (see also Burns et al., 2004).

Family advocates also emphasize the need to evaluate the strengths of the birth family and determine how best to support those strengths, while providing services to address the family's needs and to enhance its functioning. When a child is placed out of the parental home, it is mandated that planning should stipulate what the parent(s) need to do in order to facilitate family reunification, should that possibility be deemed appropriate. Placement planning should also include what support services the receiving foster family would require to meet the medical, educational, mental health, and any special needs of the child. When foster families are well supported, the likelihood of disruption of placement is decreased. The Casey Family Programs (2006) conducted a benchmark study of foster care alumni in the northwest United States; not surprisingly, it found that stability of placement, good educational opportunities, and appropriate preparation for transition into independent living were critical variables in improving outcomes, which included stable mental health.

A recent trend in local child welfare agencies has been to designate foster children as qualifying for either “therapeutic” or “traditional” placements. In my opinion, all foster placements are therapeutic. Every child who has experienced parental abuse has already been traumatized, and additionally has undergone a traumatic separation from the parental home, even though that may be in the child’s best interests. Kinship care has been advocated as a desired placement option that is preferable to foster care. Research has shown mixed outcomes of such placement. One study’s findings did not support the idea that children do better in kinship care (Clyman & Harden, 2002). On the other hand, Chamberlain et al. (2006), using placement disruption as an outcome measure, reported that nonkinship placements were more likely to be disrupted. Yet another study, which was European-based (Holtan, Ronning, Handegard, & Sourander, 2005), found that more positive outcomes (as measured by scores on the Child Behavioral Checklist) were associated with kinship care within a child’s community. These studies are by no means comparable because of different target populations, different outcome measures, and different research questions and strategies.

The issue that remains unresolved is whether it is best to keep children within their communities of origin and with extended family members, or to remove them to unknown foster families in unfamiliar communities. One might argue that only assessment of each individual child’s circumstances can determine what should be implemented. If some communities and families of origin are unstable and unhealthy places to raise children, are they not then *de facto* inappropriate placements for maltreated children? Without aggressive and sustained intervention in both the families and the communities, how can families learn to do a better job of keeping their children safe? A 6-year study of outcomes in adolescents reunified with their birth families, versus a comparison group of nonreunified youth, showed that the behavioral health outcomes were worse for the reunified youth (Taussig, Clyman, & Landsverk, 2001). These findings raise concerns that abusing families are not demonstrating sufficient improvement in functioning to justify reunification. It is important, however, to conduct further research to identify any critical variables that can be influenced to ensure that kinship care, within-community placement, and reunification have more predictably successful outcomes.

WHY DO PARENTS ABUSE THEIR CHILDREN?

There is no simple answer to the question of why parents abuse their children. Federal data derived from states’ CPS reports to the Administration for Children and Families in 2004 (Rosenberg & Wilcox, 2006) indicate that in substantiated cases, 18.3% are victims of fathers as the sole perpetrators of maltreatment.

Mothers were the sole perpetrators in 38.8% of the cases, and 18.3% were victimized by both parents. It is speculated that the fact that mothers bear the primary burden of caretaking may account for their being twice as likely as fathers to abuse their children. Parents "at risk" for abusing their children often experience multiple and severe psychosocial stressors (Nair, Schuler, Black, Kettinger, & Harrington, 2003). One study, from French-speaking Canada, of mothers as repeat perpetrators (Boulet, Ethier, & Couture, 2004) reported that those mothers had themselves suffered more traumatic events in their lives related to abuse, separations, and foster care placements. These findings corroborate the concept of the "intergenerational cycle of violence" that one frequently observes in abusing families.

One consistent finding since the 1980s has been, as noted earlier, that substance abuse by parents is highly correlated with the entrance of children into the foster care system. Indeed, as many as 80% of parents who abuse their children have substance abuse problems (Dore & Doris, 1998; Donohue, 2004). Another finding has been that domestic and community violence also occur more frequently among abusing parents than in the population at large. Moreover, the prevalences of teenage pregnancy and of multiple births among the parents of children referred into the child welfare system are higher than in the general population (Olds et al., 1998). Single parenthood has also been shown to be more highly correlated with child abuse. Rosenberg and Wilcox (2006) reported:

> The overall rate of child maltreatment among single-parent families was almost double that of the rate among two-parent families: 27.4 children per 1,000 were maltreated in single-parent families, compared to 15.5 per 1,000 in two-parent families. One national study found that 7 percent of children who had lived with one parent had ever been sexually abused, compared to 4 percent of children who lived with both biological parents.

Finally, abusing parents have been shown to have a higher high school dropout rate and a higher dependency on Temporary Assistance for Needy Families. What this all means is that where there exist high rates of poverty, substance abuse, poor educational attainment, domestic and community violence, single parenthood, and teenage pregnancy, the risks of children being abused increase (Center for the Study of Social Policy, 2003; Toni, 2006). These sociodemographic factors all tend to increase the psychosocial stressors on parents raising children. So while each factor may not, in and of itself, be causative in child abuse, the cumulative effect of those stressors on the parents could be indirectly "causative" in facilitating the loss of parental control that results in child abuse.

Furthermore, parents who have themselves experienced childhood abuse, unless they acquire new knowledge, skills, and attitudes about appropriate child rearing, are likely to raise children the way they have been raised themselves. Corporal punishment is still practiced by a majority of parents in the United States. While most instances of corporal punishment may not meet statutory criteria for child abuse, it is a practice that sets the stage for physical child abuse, since it establishes the principle that hitting a child (an aggressive and violent act) is acceptable. The child abuse rolls are full of incidents of parents "simply" disciplining their children and essentially "going overboard" with such violent disciplinary practices that they cross over into substantiated child abuse. One very tragic case in the District of Columbia was that of a parent who was assisting his son with homework and teaching him how to tell time. Unfortunately, the child had some difficulty understanding the concept, and the father, in his frustration, resorted to harsh physical discipline, which resulted in the untimely death of his son. The AACAP (*www.aacap.org*) and the American Academy of Pediatrics (*www.aap.org*) advocate against corporal punishment of children, instead recommending that caretaking adults learn how to manage disciplinary issues with nonphysical behavior management techniques.

The role of parental psychiatric illness in child abuse also needs to be better understood (Ackerson, 2003). The nationally publicized case of Andrea Yates, the Texas mother who drowned five of her children, was an extreme case of a mother who suffered from postpartum psychosis (a very serious and often overlooked major mental disorder), which resulted in the five child fatalities. I myself once had to intervene in a case of a child's guardian (a relative) who brought her charge to the hospital emergency room. There was nothing wrong with the child, but the adult was psychotic and could have harmed the child because of the content of her delusional thinking. The crisis intervention in this case was to take the adult to the nearby hospital and seek an emergency psychiatric admission for her. If one considers that substance abuse and psychiatric illness can often be comorbid, and that most child-abusing parents also use substances, the likelihood of the existence of psychiatric illness is high in the abusing population.

In another case, a mother diagnosed with a major chronic and persistent mental illness raised some concern among the professional staff about her parenting capacity when she took her toddler to a specialty service at the hospital. I was called to conduct an emergency consultation to determine whether CPS should be called in. Though the mother was indeed mentally ill, it was clear that she was very positively invested in her child, exercised appropriate supervision and monitoring, and cared for him satisfactorily. I recommended that instead of having CPS remove the child from the mother, the social welfare department should provide homemaker services to support this mother's parenting, while also providing monitoring. The child was enrolled in a therapeutic nursery school; the mother received subsidized housing and was visited frequently by a social worker.

CAN SPECIAL NEEDS OF CHILDREN PLAY A ROLE IN PARENTAL ABUSE?

The question of how children's special needs may relate to parental abuse is one that is often considered by clinicians. The concept of the "identified" or "targeted" child is one that is familiar to workers in the child abuse arena. When there are multiple siblings in a household, why might one child be singled out for abuse? What makes that child more vulnerable? Children with special needs are overrepresented in the child welfare system (Leslie et al., 2005; Shannon, 2006). Whether they have medical illnesses, physical disabilities, developmental delays, or psychiatric disorders, they undoubtedly require more emotional, financial, and time resources from their parents. Statistics (McDonald & Associates, 2006) indicate that children with the following disabilities are 68% more likely than nondisabled children to be victims of maltreatment:

- Mental retardation
- Emotional disturbance
- Visual impairment
- Learning disability
- Physical disability
- Behavioral problems
- Other medical problems

Although there may be accessible resources for children with special physical or developmental needs, the available resources for psychiatric illness are woefully inadequate. The national shortage of child and adolescent psychiatrists and other child mental health professionals has been brought to the attention of the U.S. Congress by child-serving organizations, including AACAP and CWLA (2004). Several states' legislatures have been made aware of the practice of parents voluntarily relinquishing custody of their children to the state so that needed mental health services can be provided to their children (Lyons & Rogers, 2004). When already stressed parents have to contend with the difficult behaviors that may accompany psychiatric disorders in their children, and they have no understanding of the illness and no access to diagnosis or treatment, they indeed may perceive those children as "bad" and causing too much trouble. Add to that scenario parental substance abuse, and it is not difficult to understand that such a "mix" creates a volatile and combustible situation where impulsive and aggressive actions by an overwhelmed parent are more likely to occur.

The most commonly diagnosed psychiatric disorder in children is attention-deficit/hyperactivity disorder (ADHD). The core symptoms of ADHD are hyperactivity, impulsivity, and distractibility. The disorder "plays out" within families as the afflicted child's having trouble with "not listening" (parents translate this into the child's being noncompliant and disobedient), "acting without thinking," always being "on the go," and often being excessively playful and clowning around. In many cases of ADHD, learning problems or formally diagnosable learning disabilities may be comorbid. School performance and social relatedness problems are also common. ADHD is only one example of how psychiatric illness in a child can result in challenging behaviors that may add to the parental stressors and tip the balance of risk factors toward child abuse. As a child and adolescent psychiatrist, I have treated many such children; the most meaningful positive outcomes in these cases are improved parent–child and child–sibling relationships.

CASE EXAMPLE

The following composite case report is a "story" that most caseworkers in the child welfare system are likely to encounter.

Family Composition

Johnny was a 7-year-old boy, the oldest of four children, the youngest being a 16-month-old toddler. His mother was 22 years old and an unemployed single parent. She had no information about the whereabouts of Johnny's father, who was himself a teenager when she became pregnant by him. They both dropped out of school, which she had always found to be difficult. She went on to have other sexual liaisons, resulting in three more births, but none of the fathers stayed with her or assisted with supporting the children. Her mother had been helping with the children, but she was now too ill with hypertension and diabetes to assist her daughter with raising the children. Johnny's mother never grew up with her own father and had no connection to him or his family. Essentially, she was socially isolated and preferred to be private about family matters, so she did not seek out social supports; nor was she connected to a faith-based organization.

Johnny was expected to be "the man of the house" and to function as a substitute parent with his younger siblings. His mother often yelled at him, struck him for not doing as she expected him to, and told him that he made her life difficult. His typical childhood behavior was not tolerated by his mother, who was overwhelmed by the normal demands of her children. This situation was exacerbated by Johnny's being identified by his teacher as demonstrating behaviors consistent with ADHD. His mother was advised to have him evaluated, but she failed to follow through. The mother became depressed and feared that she had "lost out" on the "fun" of her youth. She felt that she was entitled to reclaim that lost youth with adding some frivolity to her life. The mother began to go out to nightclubs, have various boyfriends, and use alcohol and other recreational drugs. She used a significant portion of her public assistance money to buy herself clothes, go to the hairdresser, and visit the manicurist; she attended less and less to the nutritional and clothing needs of the children.

Johnny began to beg in the neighborhood and "surf" the garbage of the neighbors, so that he and his siblings would not go hungry. His school attendance fell off dramatically. When he did show up at school, he appeared to be tired, hungry, and dirty. He was also hyperactive, impulsive, aggressive, and defiant. He was teased by the other children about his clothes and about his mother, and he responded by fighting, which escalated to his hurting another child. The mother was notified about a school suspension and was asked to come to a meeting at school. This became the tipping point for her, and in a rage she beat Johnny with her bare hands and repeatedly struck his head against the wall, knocking him unconscious. The mother was shocked by this outcome and went out yelling for help. At this point a neighbor called for medical assistance. The mother was inebriated and smoked incessantly.

Johnny was admitted in critical condition to the hospital, but survived. Social services became involved immediately, and a caseworker went to the home to make an emergency assessment. The lack of food, the filth of the surroundings, and the unkempt appearance of the children were all obvious signs of gross neglect. This situation met legal criteria for compromised safety and endangerment, and all of the children were removed from the home that evening. Emergency medical examinations were requested to determine whether there might be urgent medical needs to be addressed. All the children were found to have tinea corporis and tinea capitis (ringworm of the body and the head), for which medication was prescribed. Fortunately, a licensed foster care family with a large enough home to keep all the children together was located.

Assessment

While Johnny was still hospitalized (but after his condition stabilized), he received a psychiatric evaluation, was diagnosed with both ADHD and an anxiety disorder, and was referred for comprehensive psychological and educational testing so that his educational needs could be addressed. The consulting psychiatrist, who was asked to consider the possibility of family reunification, made the recommendation that Johnny's mother should have court-ordered psychological testing and psychiatric and substance abuse evaluations as soon as possible, in order to make an early determination about her needs and to provide the appropriate interventions to her. It was not surprising that the mother was also diagnosed with ADHD, as well as specific learning disabilities and depression.

Treatment

With prompt and collateral assessments of both the identified child victim and the parent, a treatment plan was put into effect within 45 days after the removal of Johnny and his siblings from their home. (As the description above has made clear, this removal was necessary.) Johnny's mother was placed into residential treatment, where she received aggressive treatment for her dual diagnoses. Upon discharge, she was enrolled in an evening special education program and ongoing outpatient mental health and substance abuse treatment. She was also provided with an older mentor from Parents Anonymous—a woman recovering from addiction who related well to the mother and was a tremendous support during some challenging times that she faced with her recovery, as well as with Johnny as they worked on repairing their relationship.

Johnny was seen by a child psychiatrist for medication management, and by a therapist with special training in work with maltreated children. Play therapy using sandplay techniques (Turner, 2005; Kalff, 2003) was utilized, as well as cognitive techniques (especially cognitive restructuring) appropriate for a child his age. Johnny came to understand how his ADHD affected him, and how to use both his medication and his own mental abilities to minimize its negative effects. He was helped to appreciate the strengths he had demonstrated in caring for his siblings, and was shown how to develop them further, but he also learned how to let the adults take over the job of raising the children and to work on being a child himself. In addition, he came to understand how his mother's depression and substance abuse had contributed to the abuse and neglect. With therapeutic help, the mother was able to apologize to and work on reconciliation with Johnny. The mother's mentor, her own mother, Johnny's foster parents, his social worker, and his therapist maintained excellent collaboration.

Over the next 12 months, the mother "graduated" to supervised visits with her children. The permanency plan was finalized as reunification, with specific goals set for the child welfare, mental health, and education services. The mother's plan included assistance with reproductive and sexual health, continued mental health care, parenting education (to include in-home child care with active modeling to handle the children with different developmental needs), and a plan for the mother to carve out appropriate recreational time for herself. She also maintained active involvement with Parents Anonymous and with Alcoholics Anonymous. Johnny had a mentor who visited with him weekly. His mental health stabilized; his academic performance, as well as his behaviors, improved; and he began to enjoy age-appropriate activities and friendships.

Commentary

The lay public is not very aware of the existence of psychiatric disorders in children, or the toll they take on the lives of children and their families. It is estimated that about 12 million children and adolescents have diagnosable psychiatric disorders, yet about 80% never receive any attention to their problems. The neuroscience field is now much better informed than ever before about the workings of the brain, and we now know that *psychiatric illnesses are brain-based disorders*. The population of children who move into the child welfare system is actually the most psychiatrically vulnerable among children (Pew Commission on Children in Foster Child, 2004). While ADHD is one childhood diagnosis that has received media attention, children also suffer from depression, anxiety disorders, attachment disorders, bipolar disorders, Tourette's syndrome, autism spectrum disorders, posttraumatic stress disorder, and other disorders of thinking, behavior, emotion, social relatedness, and self-regulation. These illnesses can result in challenging interpersonal interactions, especially within families where there are multiple other parental stressors, parental psychiatric illness, and/or substance abuse, and where already fragile coping skills may give way to child abuse.

THE ROLE OF PREVENTIVE INTERVENTION

The Elmira Study by David Olds and colleagues (Olds et al., 1998) is a gold-standard research study that has demonstrated the success of a home visitation intervention conducted by registered nurses with teenage parents. The impact of regular home visits by a registered nurse was shown to be substantial, since the incidence of child abuse and of juvenile delinquency fell significantly as a result of that intervention. Although that particular program can claim excellent and successful results, some other attempts, for example, the Hawaii healthy start programs (El-Kamary et al., 2004) to replicate the program have not been quite as robust in their outcomes.

Other interventions that target parents are sponsored by Parents Anonymous, a national self-help group of parents that has spawned local organizations aimed at engaging parents in positive parenting with community support in order to prevent child abuse. A publication by this organization states, "National research definitively confirms the effectiveness of Parents Anonymous in diminishing the impact of risk factors while dramatically increasing the resiliency of parents and children, resulting in the prevention of child abuse and neglect" (Pion-Berlin & Polinsky, 2000, p. 2). The organization further highlights its role in interrupting the cycle of negative social adaptation, which includes "social problems such as juvenile delinquency, crime, emotional and developmental problems, substance abuse, poor school performance, homelessness, and unemployment" (Pion-Berlin & Polinsky, 2000, p. 5).

WHAT CAN BE DONE TO DECREASE THE PREVALENCE OF PARENTAL ABUSE?

Given what we know about the high prevalence of substance abuse among maltreating parents, the single most important area to be targeted in efforts to decrease child maltreatment is substance abuse (Kerwin, 2005; Velez et al., 2004). The research in this area of study has been very illuminating, and should lead to more comprehensive and successful interventions (Donohue, 2004). A long-term, visionary approach should be undertaken, with efforts being targeted toward youngsters in middle school, as well as substance-using adults who are parents. The National Institute on Drug Abuse has undertaken a media campaign to prevent the abuse of alcohol (the most widely abused drug because of its easy availability) in early adolescence, because research shows that youth who begin drinking prior to the age of 14 are more likely to grow up to be adults with alcohol abuse problems. It appears that early exposure to alcohol primes the brain to be more susceptible to later abuse. Delaying drinking until early adulthood decreases the likelihood of alcohol addiction. Schools, churches, and communities at large should join this effort and implement this prevention campaign at the grassroots level.

The second area I would recommend targeting in efforts to decrease parental abuse is that of early teenage sexual activity and the resulting teenage births. In particular, foster care enrollees are more likely than their cohorts who are not in foster care to become teenage parents (Carpenter, Clyman, Davidson, & Steiner, 2001). Teenage pregnancy and single parenthood are risk factors for poverty, and these three factors are all in the cluster that increases the risk of parental abuse.

The research shows that when teenagers delay their sexual debut to early adulthood, they exercise more control over their reproductive functioning, delay parenting, and are more likely to complete high school (and thus more employable) (Donenberg, Bryant, Emerson, Wilson, & Pasch, 2003). Resistance to having comprehensive sex education in public schools is unfortunate, because teens begin to explore their sexuality in middle school. Comprehensive sex education should include family planning that provides adolescents with information about the social and emotional development of children, as well as the role of parents in providing for their children's well-being through good-enough nurturing, medical care, appropriate education, adequate housing, avoidance of domestic violence or substance abuse, and raising children with a sense of moral and civic responsibility. Such a comprehensive approach would need to be linked to a community, social, and political network that undertakes the task of providing a cohort of students with the essential services that they need for their successful development. This is a real challenge to our society.

Educating all parents about good parenting practices is a low-cost intervention that can be implemented with all families of pregnant women. Depending on which risk factors for parental abuse are present, the educational curriculum could be tailored to address the specific needs of the parents. As noted above, Parents Anonymous serves parents at risk of becoming abusive, and it has a history of decreasing abuse in these participants. Undoubtedly, the peer support provided by membership plays a critical role in promoting and sustaining good parenting practices. Schools could become the hub of communities where activities such as Parent Anonymous meetings can be held regularly.

It is indeed at the local level that we need to concentrate on building healthy communities and healthy families. The organization Families Support America (*www.fsnh.org/fp.fsa*) has stated that communities with adequate infrastructure, including housing, health care services, employment, and educational opportunities, are necessary to support the strengthening of families. It is only within healthy communities that neighbors can be expected to collectively assume the responsibility for the healthy development of all children, and to provide timely and appropriate support for families at risk of abuse. Families can exchange respite care, take turns organizing events for families and kids, join forces to organize community cleanups, arrange community celebrations honoring local heroes and heroines, and celebrate patriotic holidays such as the Fourth of July and Memorial Day.

I grew up in a mixed-SES community where my father was the superintendent of schools. At one time the community began having some gang-related activity; my father convinced the local department of education to open up an unused school for use as a recreational facility, and he solicited funds and sponsorship from a corporation. This intervention was successful in aborting the development of gangs in the community. Because my parents were considered and respected as elders in the community, they were sought out to counsel young families and to assist with redirecting youth who were "acting out." The entire community would be spectators to the Sunday soccer and cricket games that took place after church and Sunday lunch. Although the youth may have felt that the eyes of all parents were always on them, it was reassuring to know that the community had a cohesive sense of values and expectations of behavior for their children. Parental peer support was an intangible presence that pervaded the community culture. The collective group of parents delighted in the successes of the youth in the community, and equally shared in the responsibility for reprimanding the youth when necessary, and for reporting unacceptable and deviant behavior to parents. And all of that instant communication occurred without cell phones! People sought out each other and spoke with their neighbors.

SUMMARY

The problem of parental abuse of their children remains very troubling. Three million referrals to CPS in a single year is a staggering number (McDonald & Associates, 2006). With 15.2% of those children having substantiated abuse that resulted in out-of-home placement, the child welfare system is faced with a formidable problem. Abuse can have long-term effects on children and their families. Although all abused children do not grow up to be abusing adults, they are at higher risk of abusing their children, and many suffer chronic and persistent psychological problems themselves (Garwood & Close, 2001).

The longitudinal trajectory of children who are removed from parental homes into foster care is not encouraging. Children in foster care are at high risk of having mental, medical, developmental, educational, and social problems. Foster care placement simply has not turned out to be a good "solution" to the problem of parent abuse. That does not mean that there are not many individual success stories of children who were fostered and went on to live well adjusted and meaningful lives as contributing citizens of society. But foster care graduates are overrepresented among the homeless, incarcerated, and unemployed populations. Societal interventions have failed to reduce the number of maltreated children going into out-of-home care. Too many of their birth parents are still failing to exercise reproductive control, living in poverty, abusing substances, experiencing violence in their lives, having serious medical problems (including HIV/AIDS), experiencing homelessness, and being shut out of the employment market.

Most parents do not set out with malevolent intentions to harm their children. However, the stress of adverse psychosocial risk factors, combined with a compromised mental state, can unfortunately create an abuse-prone situation, resulting in needless and tragic maltreatment of children. What is most disturbing, however, is that, as the Schorrs (Schorr with Schorr, 1988) wrote almost 18 years ago, solutions are indeed "within our reach." Instead, recent economic trends in the United States indicate that while the overall economy is stable, poverty is now on the rise, with an increasing number of people being added to the uninsured rolls in 2006. That should sound the alarm for us to be alert to the possibility that child maltreatment may take a turn for the worse. We need to institute a multipronged, aggressive intervention strategy to avoid such a tragic outcome.

Study Questions

1. If you could design a "village" that would be conducive to child rearing, what would you include as the major elements of the infrastructure for this "village"?
2. You have an opportunity to start up a new foster care program. Funding is not an issue. How will you work with a community to take ownership of the program?
3. What are the challenges to reducing child maltreatment? How might you address them?

Role-Play Exercises

1. Imagine a scenario with three participants: One is a victimized child; one is the alleged parent perpetrator; and one is the caseworker who has come in to remove the child, who has been physically abused and neglected. Develop a 5-minute skit to act out this scenario.
2. Have one person play the role of a young teenage mother with three kids who are fighting, being loud, and not listening. The mother looks on and tells her story in a monologue describing her social circumstances, identifying the risk factors discussed in the chapter. One child approaches her, whining and demanding; at that point she "loses it," and strikes out and physically harms the child.
3. Imagine that you are a child being placed in a new foster home far away from the neighborhood you have always known. It's a beautiful home, and you have your own room for the first time. Your social worker tells you how very lucky you are to get this family and have nice things. You are relieved to be away from the abuse, which you reported to your teacher, but you miss your family and your neighborhood terribly. Say out loud what you imagine is going through the mind of the child (about 8 years old).

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Chapter 6

Trauma-Focused Cognitive-Behavioral Therapy for Child Sexual Abuse and Exposure to Domestic Violence

CASE OF MARY, AGE 6

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Interpersonal violence experienced in childhood has been repeatedly found to be associated with negative psychosocial consequences, with multiple exposures increasing the risk of adverse effects (Felitti et al., 1998; Teicher, Samson, Polcari, & McGreenery, 2006). And sadly, it is not uncommon for youngsters to experience one or more forms of direct or indirect victimization by the time they are 18 years of age. One study, in fact, found that children who reported any type of sexual victimization were very likely to experience other types of victimization as well (Finkelhor, Ormrod, Turner, & Hamby, 2005).

While there are encouraging indications that there have been recent significant declines in some forms of childhood victimization, including sexual abuse and exposure to domestic violence, it is important to note that overall rates of these childhood traumas remain quite high (Finkelhor & Jones, 2006). Due to differing definitions, approaches, and populations surveyed, estimates of sexual victimization and exposure to domestic violence in childhood vary considerably across studies; however, there appears to be little doubt that millions of children have been exposed to these types of experiences in the United States each year (Holden, Geffner, & Jouriles, 1998; Finkehor et al., 2005).

This chapter briefly reviews the potential effects of exposure to sexual and domestic violence in childhood, and offers an overview of a treatment approach that has been found to be valuable in helping children overcome the aftereffects of such exposure. The implementation of trauma-focused cognitive-behavioral therapy (TF-CBT) is presented in the form of a case study involving a 6-year-old girl who experienced both sexual abuse and exposure to domestic violence.

Over the years, research has repeatedly demonstrated children exposed to sexual abuse (Beitchman, Zucker, Hood, daCosta, & Akman, 1992; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Conte & Berliner, 1988) and/or domestic violence (Fantuzzo & Mohr, 1999; Graham-Bermann, 2001; Groves, 1999; Margolin, 1998; Rossman, 2001) may suffer significant psychosocial difficulties. Moreover, children who are exposed to domestic violence often endure other types of abusive experiences (Cummings, 1998). McCloskey, Figueredo, and Koss (1995) have indicated that different forms of abuse in the home are interrelated, and that children of battered women are at risk for child abuse. Gibson and Gutierrez (1991) have suggested that children exposed to marital violence have a 40–60% chance of being physically abused. Additional statistics have shown that a child exposed to domestic violence may be 12 to 14 more times more likely to suffer sexual abuse at the hands of his or her mother's partner, and may be 7 times more likely to be abused sexually by a perpetrator outside the home (McCloskey et al., 1995). Fifty-two percent of children and adolescents being evaluated in a sexual abuse clinic reported domestic violence in their home (Kellogg & Menard, 2003). Children who have both been exposed to domestic violence and endured child abuse are subject to what has been referred to as a "double whammy" (Hughes, Parkinson, & Vargo, 1989). Indeed, studies have demonstrated that being exposed to both domestic violence and child abuse may have a greater adverse impact on children than exposure to either domestic violence or child abuse alone (Sternberg et al., 1993; Levendosky & Graham-Bermann, 2001).

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

Given the documented negative effects of violence in childhood, steps should be taken to provide early, effective interventions whenever possible. TF-CBT has been proven efficacious in helping children overcome posttraumatic stress disorder (PTSD), depression, feelings of shame, and other emotional/behavioral difficulties in the aftermath of sexual abuse. TF-CBT, as described by Deblinger and Heflin (1996), has been applied primarily to children who have experienced sexual abuse; however, it is now being applied to children who have suffered other kinds of trauma, such as childhood traumatic grief and domestic violence (Cohen, Mannarino, & Knudsen, 2004; Cohen, Mannarino, & Deblinger 2006). The efficacy of TF-CBT for children who have been sexually abused has been well documented in the empirical literature (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1996, 1998; Deblinger, Lippmann, & Steer, 1996; Deblinger, Stauffer, & Steer, 2001). The TF-CBT model provides psychoeducation and coping skills training. It also focuses on alleviating PTSD symptoms (such as distress regarding memories of abusive experiences or avoidance of abuse-related reminders) by helping children to directly confront abuse-related cues and memories, while encouraging the processing of feelings, thoughts, and potential misconceptions regarding the abusive experiences. Nonoffending parents are included in the treatment process to assist them in coping with their own emotional distress, while also enhancing their effectiveness in responding to their children's behavioral difficulties and therapeutic needs.

The TF-CBT model provides psychoeducation and encourages the development of coping skills, as well as the construction of a trauma narrative or some other form of gradual exposure activity (e.g., drawing, painting, writing a song or poem, reenactment with play materials, visualization, etc.) to help a child lessen his or her anxiety in confronting memories of abusive experience(s) and sharing his or her thoughts and feelings. In a gradual fashion, children are often encouraged to move from discussion of the least distressing traumatic experiences to those that are most distressing. A child who has experienced both sexual abuse and domestic violence may initially choose to process one type of experience over the other, depending on which one is less anxiety-provoking. The goal of these sessions is to help the child become more comfortable discussing the traumatic experiences, so that he or she no longer needs to actively avoid memories and other reminders of the abuse. As children's avoidance diminishes, they are often able to more effectively process the disturbing thoughts and worries that may underlie both PTSD and depressive symptomatology. Parents simultaneously receive education and skills training, while also working through and processing their own feelings and thoughts associated with the traumas endured. During the second half of treatment, parents and children participate in joint sessions designed to enhance open, effective family communication regarding the traumas as well as other issues.

THE CASE: MARY, AGE 6

Family Information

This case is a composite of several cases involving school-age children referred to our agency for treatment in the aftermath of similar traumatic experiences.

Mary was a 6-year-old girl who resided with her mother, Linda, who was 34 years of age, and her younger brother, John, who was 2 years of age. Mary attended a regular first-grade class at her local elementary school, but was experiencing some behavioral difficulties. She exhibited problems with noncompliance in school, which most often appeared as refusal to do schoolwork or general refusal to follow her teachers' or aides' directives. Linda was a full-time nursing home aide who often worked long hours, including overnight shifts. She and the children's father, Joe, had married young and were separated at the time of the initial assessment. Linda reported that the marriage was fine at first, but after Mary was born prematurely, they began having both financial and marital difficulties. Joe began to blame Linda for the mounting hospital bills, and he became increasingly angry and frustrated with the baby's frequent crying spells. He often accused Linda of being a bad mother. Over the years, Linda endured increasing verbal abuse and then physical violence at her husband's hands: At various times, he hit her, pushed her, punched her, and threatened her with a knife. On a couple of occasions, he forced her to have sexual activity with him. Linda knew that Mary had seen and heard the physical violence, and that she was scared when she saw her mom bruised and bleeding, and her dad angrily leaving the house. She also knew that Mary was beginning to show signs of aggression herself—first toward her brother, John, and then toward children in her school. Linda talked with Joe about leaving him if the violence didn't stop. Joe's response was to threaten Linda's life, and when she tried to get to a phone to call 911, he beat her so badly that she required a week of hospitalization for her injuries. Joe was arrested and jailed, and Linda also filed a restraining order against him.

Upon Linda's discharge from the hospital, she and the children moved in with her own mother, Jackie. After Linda left her husband, their daughter disclosed sexual abuse by her father to her maternal grandmother. Mary asked her grandmother if she could tell her something she was afraid to tell anyone. Jackie told her granddaughter that she could tell her anything, and Mary subsequently told her that she was very scared of her father. Jackie told Mary that it was normal for a child who had seen so much violence done to her mother to be afraid of the person who was violent. Mary began to cry, and she told her grandmother that he wasn't mean only to her mother. She then told her grandmother that her father was coming into her room on nights when her mother was working overnight at the nursing home. She said he would come into her room and read to her as he always had, but then one night he didn't just tuck her in the way he used to; he tucked her in, put his hand under her nightgown, and touched her chest and her private areas. Then he put her hand on his private part. He told her this was their new way of tucking her in, and it had to be a secret just for them. This went on for a while, but then he began to come in the bathroom and watch her taking a bath. When Mary told her father that she didn't need help washing herself, her father said she smelled, and of course she would want him to help her so she didn't smell any more, or soon other kids would smell her too and make fun of her. He began to wash Mary, first with a washcloth and then with his hands. Mary told her grandmother that soon it seemed he only wanted to wash her private part; when she would tell him to wash the rest of her body too, so it wouldn't smell any more, he would tell her to grab a washcloth and do the rest herself, and then he would leave.

Jackie thanked Mary for telling her about this, and remained as calm as possible while she kissed Mary good night and sent her to bed. Jackie told Linda about Mary's disclosure as soon as she got home from work, and they called child protective services. Linda was afraid to call, as she continued to be afraid that her husband would make good on his violent threats. However, with her mother's support Linda called, and a worker came out and talked with her and with Mary and her grandmother. Mary told the worker about her father's sexual abuse of her and about the violence she had witnessed. Her father was already in jail on charges related to the domestic violence, and the prosecutor's office filed additional charges related to the sexual abuse of Mary and then Mary's report was substantiated by the child protective services.

Presenting Problem

Following the investigation and substantiation of the child sexual abuse allegations, the family's child protective services worker recommended that Mary receive treatment to address the impact of the sexual abuse. Mary's mother agreed that her daughter needed help to cope with the sexual abuse, as well as the domestic violence she had been exposed to since birth.

Since the disclosure, Mary had been experiencing more frequent nightmares about the sexual abuse; she was clingy around her mother and grandmother; she became upset when she saw or was around older men; and she was increasingly fearful and startled easily. Before the sexual abuse disclosure was made, Mary had also begun exhibiting behavior problems: She often hit her brother and her mother, was noncompliant with her mother's requests, and was frequently uncooperative at school.

Recommendations

After a careful assessment, the therapist suggested that the mother and daughter participate in TF-CBT. Linda agreed to participate in treatment to support her daughter and to learn how to respond effectively to Mary's behavior problems. Linda was, however, very unsure that she could talk with her daughter about the domestic violence and sexual abuse, because these issues were highly upsetting. The therapist indicated that these topics would initially be addressed during separate sessions, and that later they would decide together whether it would be helpful to talk about these matters in joint parent–child sessions.

First Contact with Child and Parent

Linda and Mary met initially with the therapist for some introductions, an age-appropriate review of the assessment and general treatment plan, and an explanation about confidentiality. The therapist stated that most children and their families successfully complete treatment in approximately 12–16 sessions, but that treatment could be extended for clinical reasons if needed. Many families appreciate the length-of-treatment discussion, as it gives them a sense of control and optimism about the future. The plan as presented by the therapist was that at the beginning the mother and daughter would have separate sessions, but that toward the middle of treatment they would probably sometimes meet together.

The therapist then escorted Mary back to the waiting room and returned to meet with Linda. A battery of standardized measures had been completed prior to this first contact. (For a 6-year-old, the parent completes both her own measures and those related to the child; the measures are described in more detail later). The results of these measures were now reviewed with Linda. It was explained that Mary had some elevated levels of behavior problems in some areas, which was not surprising, given that Linda had already expressed concerns to the therapist about her daughter's behaviors. The therapist also shared that Mary had symptoms of depression and posttraumatic stress—very common responses to traumatic events experienced in childhood. The strengths both Linda and her daughter were exhibiting (e.g., their close relationship, Mary's ability to maintain good grades in school, etc.) were emphasized, however, and the therapist explained that the measures would be administered again at the end to see whether the problems had decreased or had gone away. Also, Linda's self-reports were reviewed, and her moderate levels of depressive symptoms were acknowledged. Linda stated that she was happy that she and the therapist would be able to look at the results together at the end; she also admitted some relief that treatment wouldn't go on forever, as she found it stressful just to get to the therapy appointments.

The therapist explained that when a child experiences the sorts of traumas Mary did, it is natural for a loving mom to focus on the negative changes she may see in her child's mood and behavior. However, Linda was asked to refocus her attention on her daughter's strengths. Together, Linda and the therapist listed some ways in which Mary was showing strengths and healthy behaviors (i.e., maintaining friends, cooperating with her grandmother, etc.). Linda was given homework to start paying attention to all of the behaviors Mary did well over the next week, to come up with a list of two or three things that Mary sometimes did well but she would like to see more often, and to bring them to the next session. The therapist then walked Linda out to the waiting room and escorted Mary back to her office, asking on the way if she would like water (she declined) and if she wanted to see the fish in the office tank (she accepted). One of the fish in the tank is a clownfish; many young children enjoy seeing this fish in particular, in light of the popularity of a recent Disney movie, *Finding Nemo*.

Upon entering the therapy office, the therapist asked Mary how she was doing, and she said she was OK. After asking some general questions about friends and school, the therapist attempted to have Mary practice telling all about a recent experience (i.e., to give a neutral narrative). The purpose of this was to determine how much information Mary could generally give in a spontaneous narrative format, and how capable she was of sharing her feelings and thoughts. This would help provide a baseline for understanding Mary's verbal and expressive skills in general. For example, if she didn't give a lot of information about a neutral subject, she probably wouldn't about the traumas she had experienced. If she did give a lot of detail, she was probably capable of sharing details regarding the trauma, and if there were differences, they might be attributable to trauma-related avoidance. In addition, this experience would allow Mary to practice some of the skills that would be required when she began to share her trauma narratives (Sternberg et al., 1997).

Content of Session	*Rationale/Analysis*
THERAPIST: Now I'd like for you to tell me about something that will help me to get to know you better. It can be something you did this weekend, or everything you did since after school today. Which would you like to choose?	Let's do a neutral narrative so that I can assess Mary's overall ability to verbalize details about a neutral event, and also work on rapport.
MARY: Today.	
T: OK, Why don't you go ahead and start, and tell me everything you did since you got home from school today, and how you were feeling, and even what you were saying to yourself?	
M: After school, my mom picked me up, and she took me and my brother to the park across from school. It is a big park with slides, swings, and a sandbox. (*Pause*)	
T: And what did you do in the park?	
M: I played on the swings 'cause I love swinging really high. But my mom doesn't like me to go so high, so she made me stop. I really didn't want to stop. (*Pause*)	
T: How did you feel when you were on the swings?	
M: It was fun—I was happy, but then I got mad when my mom made me stop. (*Pause*)	Great, she is able to use feeling words.
T: So first you were happy, but then you got mad. What happened next?	
M: Then I saw my friend Sally, and I asked my mom if she could come to my house, and my mom said yes.	
T: What did you think when your mom said yes?	
M: I was happy. I really like Sally. She is fun to be with, and she's my best friend.	More feelings.
T: Thank you for sharing all that about going to the park and inviting your friend to your house. It must be nice	Mary seems to be able to share quite a bit about a neutral event. Let's see how she does with the traumas.

to have a best friend like Sally. Mary, now I'd like you to tell me why you are coming to see me.	
M: I don't know.	Typical response; kids may be uncertain. Hmm. Is this avoidance, or does she really not know? Will she tell me?
T: Well, I talk with children about things that have happened to them that they need to talk about, or that someone else thinks they need to talk about. Does that give you any ideas?	
M: (*Looks at the floor for a while.*) Yes. My dad did bad stuff to me and to my mom.	She definitely looks uncomfortable now, but I will wait out this silence and see how she responds.
T: Would you like to tell me what kind of bad stuff your dad did to you and your mom?	
M: No, I don't like to tell anybody about that stuff. (*Looks down and seems upset.*)	Of course she wouldn't like to tell me. I shouldn't have posed that as a yes–no question. I'll try again with a direction rather than a question. I hope the warmth in my tone, as well as my confidence in her, will help her share.
T: I'd like you to tell me about the bad stuff your dad did to you or to your mom.	
M: (*Pause*) He hurt my mom really bad. Do I have to tell you what he did to me?	
T: I'd like you to.	
M: (*Looks down again, and speaks lower than previously.*) He touched my private parts. I didn't like it.	It's good that she's giving me some information. Let's see if she'll disclose more.
T: What else did he do?	
M: That's all.	
T: OK. Well, thank you for telling me about your father hurting your mom and touching your private parts. How does it feel to tell me about those things?	
M: It was hard to tell you, but it felt kind of good to get it out.	Although she is clearly avoidant, this is a good start, in that Mary already acknowledges some benefits of "getting it out."
T: Well, I'm so glad you did get it out.	

After this, Mary was asked whether she wanted to tell the therapist anything else about herself or things she liked to do. This seemed to build further rapport and revealed that Mary particularly enjoyed artwork—an activity that could be incorporated into treatment about the traumas. The therapist ended the session on a positive note, summarizing some of the things she had learned about Mary, while expressing enthusiasm about their plan for future sessions.

Preliminary Assessment and Treatment Plan

As noted earlier, Linda reported that subsequent to repeated exposure to the domestic violence, Mary began to exhibit noncompliant behavior in school. At times, she took on language similar to what she had heard from her father (e.g., "You can't tell me what to do, moron"). Linda also noted that when Mary's brother, John, was born, Mary had initially been very cooperative and helpful, happy to assist her mother by bringing toys or diapers or bottles for the baby. However, more recently Mary had become jealous, frequently hitting her brother or calling him names similar to those her father used to call her mother. Linda further reported that Mary used to idolize her father when he wasn't violent, and that she had eagerly accompanied him on errands and enjoyed spending time with him during his calmer periods. However, at one point, Mary began to become increasingly clingy toward her mother and more fearful of her father; at the time, Linda had attributed these changes to an increase in the violence toward herself, or a greater understanding of the violence on Mary's part. After Mary disclosed the sexual abuse, Linda attributed this change in her behavior to the sexual abuse. Mary had now generalized her fear of her father to being fearful of older men in general, and she became overtly upset if she was around men who resembled her father. She continued to exhibit noncompliant behavior in school as well.

As mentioned above, Linda had completed a battery of standardized measures related to her own and her daughter's functioning. Parents or other caregivers who are participating in a child's treatment complete such a battery, to assess for their own depressive symptoms, their distress symptoms related specifically to the child's traumas, and their perspectives on the child's behaviors. The Beck Depression Inventory (BDI), a self-report measure of depressive symptoms, and the Impact of Events Scale (IES), a self-report measure assessing the adults' own distress related to the traumas of the child, are utilized. The Child Behavior Checklist (CBCL) enables adults to rate the child's general behaviors, and the Child Sexual Behavior Inventory (CSBI) is helpful in cases where the referral is made for child sexual abuse and/or sexually reactive behavior. The child and adults are also separately administered a semistructured interview, the Schedule for Affective Disorders and Schizophrenia for School-Age Children—Present and Lifetime Version (K-SADS-PL), to assess for the child's symptoms of posttraumatic stress or PTSD. In this case, since Mary was only 6 years old, she did not complete any of the self-report measures typically utilized with older children. However, the therapist did administer the K-SADS-PL for clinical value as well, since even at this young age, children often report posttraumatic stress symptoms of which parents or caregivers are unaware.

The therapist reviewed the results of the measures with Linda, as described above. The therapist also reviewed Mary's report of symptoms of PTSD that she had not shared with her mother, such as fear related to reminders of the sexual abuse and domestic violence, including looking at photos and driving by their old house. The therapist normalized these reactions, and emphasized that often parents are not aware of some of their children's internal fears and difficulties.

The short-term individual treatment for Mary would be TF-CBT, focusing on reducing Mary's symptoms of PTSD and depression. Goals for treatment followed the TF-CBT acronym of PRACTICE: Psychoeducation and Parenting skills, Relaxation, Affect modulation, Cognitive coping, Trauma narrative and processing, *In vivo* gradual exposure, Conjoint parent–child sessions, and Enhancing safety and posttreatment adjustment. As such, the initial goals for treatment were education and skill building. Mary received age-appropriate education about domestic violence, child sexual abuse, and other types of violence. In addition, she learned and practiced emotional expression and regulation skills, with a special emphasis on anger management. The middle phase of treatment increasingly focused on the traumas Mary had experienced. Mary was encouraged to share and process her thoughts, feelings, and memories related to both the domestic violence and the child sexual abuse. This latter component was completed by Mary via trauma narratives, plus a combination of drawings and verbal expression of her thoughts and feelings. Toward the end of treatment, Mary received age-appropriate sex education, learned about "OK" and "not-OK" touches, practiced assertiveness, and learned personal safety skills.

Treatment with Mary's mother, Linda, focused on similar skill-building and educational goals, including learning about the prevalence of, and common reactions to, child sexual abuse and exposure to domestic violence in childhood. Whereas treatment with a parent generally focuses on the child's experience, Linda was also encouraged to process her own experiences of violence to some extent, so that she could support her daughter's healing and growth. Although therapists sometimes refer mothers to their own therapists, particularly if depressive symptoms and/or dysfunctional beliefs appear to increase the risk of a mother's returning to the abusive relationship or entering into another one, this did not seem to be necessary early on in this case. Additionally, the sessions with Linda focused on demonstrating behavior management techniques and enhancing parent–child communication, so Linda could assist and support Mary not only as she continued to heal, but also as she continued to grow and face new developmental challenges.

Play Therapy Sessions and Sessions with the Mother

It should be noted that TF-CBT begins with the child's and parent's participating in separate individual sessions with the same therapist (45 minutes each with parent and child), in which treatment with the child and treatment with the child's parent/caregiver are parallel processes. Although in some cases either the child or parent might be a little ahead of the other, treatment components generally follow the same order. In other words, when the child is working on emotional expression exercises, the parent is too. The parent/caregiver is also simultaneously receiving education and learning and practicing effective parenting and communication skills throughout the course of treatment.

Session 2

The therapist met first with Linda and reviewed her homework. Linda was eager to talk about Mary's behavior over the week, which was generally noncompliant but not dangerous. The therapist then explained that while Mary's behavior problems would be discussed, the focus would really be on Linda's responses to those behaviors, because it is well known that parenting behaviors significantly influence children's behaviors. Linda presented the therapist with a list of positive behaviors she had observed in Mary, including being helpful, having good hygiene, and sometimes doing as she was asked. Upon discussion, Linda felt that she most wanted Mary to improve her listening and to do as she was asked more consistently. Linda was given guidance on using praise effectively, emphasizing the importance of being specific, avoiding "negative tags," and staying purely positive when offering praise. Linda's new homework was to praise Mary every time she listened or did as she was asked over the next week. Linda was even encouraged to make requests that she suspected Mary would comply with, so she could have more opportunities to praise her for cooperation.

Linda was then asked to tell whether there was a time during the past week when she had been feeling particularly distressed about what Mary had been through in terms of the sexual abuse and family violence. Linda was able to pinpoint a time at work when she found herself consumed with worry about Mary. After describing and getting in touch with the feelings she was experiencing (e.g., fear, anger, loss), the therapist asked Linda to try to capture the thoughts that were racing through her mind at that time. The therapist wrote the thoughts and feelings down in parallel columns, so that the thoughts were beside the corresponding feelings. A third column provided a place for Linda to record the behaviors she engaged in that stemmed from her thoughts and feelings. This list was used to work on cognitive coping and was added to later as spontaneous thoughts, feelings, or actions were verbalized by Linda. The therapist asked Linda to write down her thoughts and feelings related to the traumas her daughter experienced, over the next week. This homework helps therapists to identify parents' trauma-related thoughts that may be inaccurate or unhelpful (e.g., "My child's life is ruined"). Lastly, Linda was given information sheets about child sexual abuse and domestic violence. Although the basic facts were reviewed with Linda, she was given the homework of reading both handouts in full (not right before bedtime) and asked to bring back relevant questions to the next session if she had any.

The therapist then spent the remainder of the session with Mary. Mary was asked to come up with the longest list of feeling words that she could; as might be expected for her age, she came up with a short list of "happy," "sad," "mad," and "scared." Mary was then given some scenarios that elicited a few additional feeling words, including "embarrassed" and "shy." Mary was also asked to give examples for several of the words (e.g., situations that made her happy, sad, etc.). Since she didn't spontaneously give any trauma-related examples, she was asked to pick two different-color gel pens, make a mark with one color next to all the feelings she had about the sexual abuse, and then make a different mark with the other color next to all the feelings she had about the domestic violence (concrete language was used, such as "when your dad hurt your mom"). The therapist praised her work, and then provided some age-appropriate psychoeducation about child sexual abuse and domestic violence through use of a card game, with trauma-related as well as neutral questions on the cards. Mary picked each card from a pile and read it out loud with the therapist's assistance. She then answered each card by herself, allowing the therapist to assess what accurate information (as well as inaccurate information or dysfunctional thoughts) she had. The therapist praised her for each answer, and added accurate information when necessary. The exercise allows children to talk about the traumas they have experienced in an abstract manner, which is much less anxiety-provoking and is good preparation for the personal trauma narrative work.

Content of Session	*Rationale/Analysis*
THERAPIST: You're really doing a great job with this, Mary. Now tell me, what are some of the feelings kids in general have when they have been sexually abused?	She's really doing great with this, and she appears much more at ease than she did last week. Of course that makes sense, since that was the first time she met me.
MARY: Sad (*pauses*), mad, scared.	
T: That's true. Some children do feel sad or angry or scared. Other children feel worried or embarrassed, or like it was their fault. Great job. Now tell me how children feel if they have seen or heard their father hurt their mother.	
M: Scared their mother will die. Mad. Upset.	Her answers are age-appropriate, so let's fill in some other information, and then see if she'll relate it to her own experience. She does with some of the other questions, but won't go there with others.
T: You're right again. Some children do feel scared their mom might die. Other children might feel sad or worried or embarrassed. The important thing is that no matter how a child feels about sexual abuse or domestic violence, all of the child's feelings are OK. Now can you tell me how you felt when you were sexually abused?	
M: Angry, sad, and scared.	
T: How about when you saw your dad hurt your mom?	

M: Really, really, really scared! I thought she was going to die that last time.

T: Sounds like that was really scary and hard for you to go through. Thank you for sharing your feelings with me. You're doing a really great job.

Great job, Mary! This is why we don't just back off when a child is reluctant initially.

Session 3

Again, the therapist met first with Linda and reviewed the homework. Linda gave delighted examples of how praise was working; in particular, she had noticed Mary listening more over the week. The therapist encouraged Linda to continue offering specific and purely positive praise for cooperation (e.g., "Nice job cleaning your room" vs. "Why don't you clean your room like this all the time?").

In addition, in order to encourage better listening and cooperation in school, Linda agreed to ask the teacher to begin sending positive notes home, so that both Linda and the teacher could praise Mary for cooperative behavior at school too. Although Linda was hesitant to be "hard" on Mary, the therapist supported Linda over the sessions that followed in learning to use time out effectively in response to Mary's noncompliant and aggressive behavior. The therapist also continued to help Linda develop her own cognitive coping skills by drawing a triangle on a wipe-off board, with the words "Thoughts," "Feelings," and "Behaviors" at respective corners (see Figure 6.1), and explaining the cognitive triangle. Briefly, the therapist explained that how we think about an event—whether our thoughts are positive, negative, or neutral—influences how we feel about it and what we do about it. Therefore, if we learn to change our thoughts about something so that they are more accurate and helpful, we are likely to feel better about it and respond in a more productive way. The therapist had Linda practice a few examples of this. The therapist then looked at Linda's list of

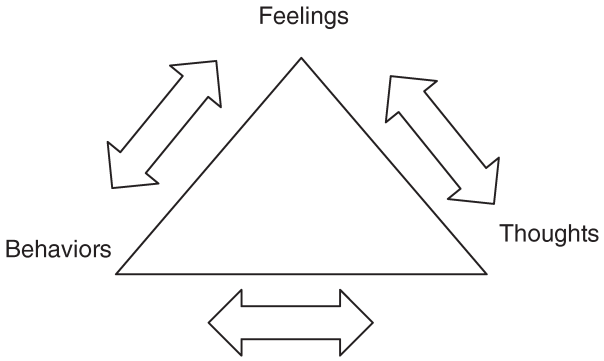

FIGURE 6.1. The cognitive triangle, as illustrated for Linda by the therapist.

thoughts from the prior week, to identify and praise healthy, productive thoughts, while also identifying and examining the accuracy of the more distressing and/or dysfunctional thoughts. The following dialogue illustrates this process.

Content of Session	*Rationale/Analysis*
THERAPIST: OK, Linda. Here you said that you think it's your fault that Mary hits other children, because you stayed in a violent situation for so long. Based on what you learned last week, do you think it's accurate? I mean, whose fault was the violence?	This is a common thought. It's tricky, because I want to reframe this without blaming her at all, but also without necessarily discouraging some natural feelings of regret for staying in a violent relationship. Still, I can help her focus on the courage she had when she did make the decision to get out and to call child protective services. This is always a tough one.
LINDA: Joe's.	
T: Yes, it's Joe's fault. Although it took a while for you to leave, you did, and by doing that, you also modeled for both of your children that violence isn't OK. So how can you change that thought to make it more accurate and helpful?	
L: I guess I could say I know Mary learned to hit by watching her father hit me, and she saw that for a long time. But when I left, I showed her that it isn't OK to be violent or accept violence, and now that we are all safe, she can learn other, better ways to handle being mad, and I will help her.	Nice job! That's exactly it. I hope that if she can get the others this easily, analyzing and changing her thoughts can come somewhat naturally to her and will start helping her right away.
T: That's great, Linda. If you think that way, how do you feel?	
L: Better. At least less like it's my fault and more like it will get better.	
T: So do you think that from now on, starting today, if you blame yourself, you can replace that thought with this one, so you can feel better?	
L: Yes. I can try.	Good start. I have to remember to give her homework about this.
T: Great, that's how it works. Let's look at another thought. Here you said that you are beginning to see improvements in Mary's behavior. That is another great thought that maybe you could say to yourself when you find yourself worrying about Mary's behavior.	

L: I am excited that she is already doing better.	She seems to be catching on to cognitive coping.
T: That's great, and make sure you give yourself credit for helping Mary make those changes.	

The therapist then spent some time explaining the rationale for beginning to encourage Mary to write or draw about her traumatic experiences. In meeting with an older child or adolescent, a therapist will put the cognitive triangle on the board and explain cognitive coping the same way. However, while the therapist may elicit the child's trauma-related thoughts, feelings, and behaviors, the therapist will not try to dispute and replace these thoughts (unless there are clinically compelling reasons) until much of the trauma narrative is completed, so that the child doesn't begin censoring thoughts before getting in touch with his or her innermost thoughts and feelings. For example, if a therapist begins disputing the dysfunctional thought "It's my fault" too soon, some children will know to say, "It's not my fault," but they may not really internalize that belief. With a young child like Mary, a therapist can read a book about how thoughts influence behaviors, such as *The Hyena Who Lost Her Laugh*, and discuss it interactively. It helps to practice cognitive coping skills about nontraumatic events before focusing on trauma-related thoughts. These skills can then be utilized in and out of treatment, particularly for anger management. For example, when Mary hit her brother this week, what did she think? How did she feel? What did she do? What could she say (i.e., think) to herself if she feels angry in a situation like that in the future? Then how would she feel? What could she do instead of hitting?

During this initial phase of treatment, Mary was also taught relaxation skills. She seemed to enjoy learning the difference between tense body states and relaxed states by imagining herself as a tin soldier versus a rag doll.

Sessions 4–10

The middle part of treatment is dedicated to trauma-focused work, generally through the production of a child's trauma narrative. During this phase of treatment, the therapist may need to periodically review the rationale for the child's beginning to write and create a picture book about his or her experiences. In general, this might encompass only about four to five sessions; however, because Mary had experienced chronic exposure to violence and repeated sexual abuse, the therapist added sessions so that Mary could have more time to process the multiple traumas she suffered. A typical trauma narrative includes the child's introduction; pages about the first, middle, and last times each trauma happened; pages about the most scary incidents; pages about the disclosure(s); and a final chapter about what has been learned in therapy and/or what the child is looking forward to in the future. Some children may have an easier time discussing one trauma or another, and typically will choose to talk more about the less anxiety-provoking traumas first. Mary had an easier time discussing the domestic violence than the sexual abuse. The therapist hypothesized that this was because it was easier to process her exposure as an observer than her own direct experience, and also because her father had pledged her to secrecy regarding the sexual abuse.

Sessions with Linda each week continued to focus on cognitive coping and homework, while addressing various behavior management skills such as differential attention, giving effective instructions, and the effective use of time out for aggressive behaviors. At the start of each session, the therapist and Linda reviewed parent–child interactions during the prior week, regardless of whether Linda expressed difficulties or reported things going well, in order to see if she was using parenting skills effectively. The rest of the session time with Linda was used to share Mary's trauma narratives as they were completed, which consisted of drawings and brief descriptive sentences, as is common with young children. The therapist encouraged Linda to share her own experiences of how she reacted at the time of Mary's disclosure of sexual abuse, while also helping her explore and process her own thoughts and feelings, and disputing dysfunctional thoughts as necessary.

In reviewing her daughter's work, Linda learned how much her children had really been exposed to the domestic violence. Over time, the therapist also explored Linda's progress, and as anticipated, she reported more positive thoughts and less self-blame (see Figure 6.2). However, Linda also acknowledged still having loving feelings for her husband and fleeting thoughts of returning to

Distressing Event: Mary started picking on her brother and hit him hard on the back.

Thoughts	Feelings	Behaviors	Distress Level (1–10)
My daughter will never be the same. She is so angry and aggressive now. I've ruined my children's lives. Why did I stay for so long?	Scared Helpless	Yelled at both kids and went in my room and cried.	9
I stayed because I wanted the family to be together. But I will not accept violence in a relationship again. I am going to counseling now, and am beginning to see changes in myself and my children. My children are young, and they are going to be OK with help from counseling and me!	Less scared Hopeful	Calmed down/wrote thoughts. Reviewed rules about hitting and time out with kids, and gave Mary a time out. Later praised Mary for reading to her brother for a few minutes. Felt proud of myself.	4

Distress Levels: 1 = Little to No Distress, 10 = Highest Level of Distress

FIGURE 6.2. An example of how changing from negative to more positive thoughts helped Linda toward more positive feelings and behaviors.

him in the future. The therapist normalized these feelings, helping Linda to process her feelings of loss for what could have been, while simultaneously encouraging her to review what life had been like for her and her children as the violence escalated. Much time was also spent with Linda exploring her own feelings about the violence the children had been exposed to, as well as the discovery that her daughter had been sexually abused. In sessions, Linda practiced using the information she had learned to dispute some of her troubling thoughts and worries, and she was encouraged to utilize relaxation and cognitive coping skills at home to manage her distress.

The therapist began the fourth session with Mary by repeating the rationale for talking and learning about sexual abuse, and reading a book called *Please Tell!: A Child's Story about Sexual Abuse*. Mary seemed to relate to the experiences of the child in the book, and she asked appropriate questions. Mary was then encouraged to write her own book about what had happened with her father. The therapist presented the book format as one option, and said that sometimes children also choose to share their experiences in a talk show format, or even to write poems or songs. Mary chose to do a book, drawing pictures for each chapter, and dictating the words to go along with each picture as the therapist wrote them down. Using art, like play, often makes it easier for young children to talk about traumatic issues. Mary's book included an introduction; chapters on when she told her grandmother about the sexual abuse, as well as when she talked with the police about it; chapters on the first, last, and most scary times she was sexually abused; chapters on the first, last, and most scary incidents of domestic violence; and a closing chapter about what she had learned from therapy. The following is an excerpt from a trauma narrative session.

Content of Session	*Rationale/Analysis*
Therapist: Mary, we are going to continue with your book today. Last time, you did a nice job writing and drawing about when you talked to the lady from child protection. Today I would like you to either draw or tell me about either the last time you saw your dad hurt your mom, or the time he hurt your mom that was the scariest.	Mary has been doing great with the trauma narrative after some initial avoidance. I really hope this continues today. It makes sense that she would not choose the scariest time, as that is probably the most anxiety-provoking for her. I had a feeling she would choose the last time.
Mary: The last time.	
T: Good. Here is paper so you can draw a picture of the last time you saw your dad hurt your mom. (*Gives paper and art supplies to Mary, who immediately begins drawing.*)	

M: I'm done. Here.	
T: This is really a good picture, Mary. Now just like before, I want you to tell me about it, and then I'll ask you other questions.	
M: OK. Daddy is saying bad things to Mommy and cursing at her. She is crying. Then he said, "If you don't stop crying, I'm going to give you something to cry about." She didn't stop, and he threw her into the wall and punched her in the stomach and face. She was crying and bleeding. (*Long pause*)	She is really having a much easier time with this. She is much more relaxed; she doesn't try to procrastinate; and today she seems eager to get started. This is working for her and decreasing her avoidance.
T: Where were you when this happened?	
M: Here, at the top of the stairs.	
T: What were you feeling when you heard Daddy say that if she didn't stop crying, he'd give her something to cry about?	
M: I was really scared and sad, because I knew she wouldn't stop crying and he'd hurt her. (*Therapist is taking notes.*)	I have to remember to write on another sheet of paper so the final version can accompany the picture. She's really doing a good job with this. She really seems to be back there capturing what she was feeling and what was going on in her head. I'm so proud of her. Her mother is, too. More importantly, she is proud of herself. Nice way to make surviving and overcoming traumatic experiences a source of pride.
T: You were really scared and sad. What were you saying to yourself in your head?	
M: That she was going to get hurt, and I wanted to help her, but I was scared he'd hurt me too. Then he started hitting her.	
T: That is scary. How did your body feel?	
M: Scared in my tummy. (*Long pause*)	
T: What were you saying to yourself when he started hitting your mommy?	
M: I was saying, "Stop, stop!" But the words got stuck in my mouth. It makes me feel bad that I didn't yell "Stop!" I'm so mad at myself. (*Tearful*)	Way to go, Mary! She still looks distressed when she talks about this, but her entire body language is more relaxed, and she no longer asks to stop. Good job!

T: That happens to a lot of kids, because when you're really, really scared, sometimes people just can't speak. Did you think that happened to you?

M: Kind of. I just couldn't speak.

T: Most kids react just the way you did, but you are talking about it now, aren't you?

M: Yeah!

T: Is there anything more you want to share today?

M: That's all.

T: Well, thank you for sharing that. You did a great job helping me understand what that was like for you.

We will have to review this a couple of times to alleviate her feelings of self-blame for not yelling "Stop!", but she seems to be getting it, and we will process these thoughts more after she completes her narrative.

As Mary continued to develop her book, the therapist reviewed the narratives between sessions, looking for dysfunctional thoughts (inaccurate and/or unhelpful thoughts) to process and potentially correct. As Mary was able to change the dysfunctional thoughts, more helpful thoughts were incorporated into several chapters (e.g., "When I first told, I thought my mom was mad at me, but now I know she was mad at my dad").

Preparing Mother and Daughter for Conjoint Sessions

Earlier in treatment, the therapist had explained to Mary why having open communication with her mom was important, and how therapy would help with that. The therapist explained that she would share (in a developmentally appropriate manner) what her mom was working on in therapy, and would also share some of Mary's work with her mom in their separate individual sessions. Mary was anxious about upsetting her mom, but the therapist reassured Mary that she (the therapist) would only share her work if she thought it would be helpful for Mary and her mother.

The therapist shared several chapters of Mary's trauma narrative with Linda in individual sessions with her. The therapist prepared Linda for the emotionally charged material, and encouraged Linda to share her own thoughts and feelings in reaction to hearing Mary's narratives. As Mary did, Linda became less distressed in response to her daughter's narratives as time progressed. Linda also noted that she had been unaware of her daughter's exposure to some of the domestic violence, which is not uncommon. The final, complete version of Mary's narrative would be shared with Linda in conjoint parent–child sessions toward the end of therapy.

The final phase of TF-CBT included age-appropriate sex education, a review of body safety skills, and the development of safety plans. Age-appropriate sex education was provided to Mary, with Linda's input in terms of family and cultural values. This was important, given that Mary had been introduced to sexuality in an abusive, inappropriate context. Linda was also encouraged to take a proactive approach regarding sex education in the future, such as reading *Where Did I Come From?* when Mary seemed developmentally ready.

Mary also learned body safety skills to reduce the likelihood of future revictimization. The therapist, however, emphasized to Mary that most children don't know what to do when they are sexually abused. Mary was also reminded that she, like most children, was confused and scared and did not have the skills to respond to the sexual abuse back then. It was also emphasized that children cannot be expected to stop adults from engaging in violence or abuse. Still, the therapist praised Mary for reading the book *Let's Talk about Taking Care of You!: An Educational Book about Body Safety* with her mother for homework. Moreover, the therapist reminded Mary that she did tell her grandmom about the abuse after she was feeling safe, and telling is the most important personal safety skill!

Another reason Mary needed to acquire safety skills was that her father was soon to be released on bail from prison. Despite the restraining order, Linda was concerned that Mary's father would try to threaten and harass them. Thus it seemed particularly important to develop a family safety plan to respond to such an incident, while also providing Mary with skills that would help her feel safe and confident. During the safety-planning sessions, Mary learned and role-played how to make 911 phone calls in case her father violated the restraining order. She practiced what to say with operators who were both easy to talk to and difficult to deal with, to increase her chance of success in case she needed to call in real life. Mary learned about "OK," "not-OK," and "confusing" touches, and she was assured that she had the right to say "no" to not-OK touches. She also learned what to say if someone tried to give her a not-OK touch, and she practiced doing this assertively by looking someone in the eye, standing up tall, and using her strong voice. Finally, she practiced saying "no," getting away, and telling in response to any not-OK or confusing touch.

Sessions 10–14 (Conjoint Parent–Child Sessions)

After the therapist shared Mary's trauma narrative with Linda over the course of several sessions, the therapist determined that Linda was emotionally ready to participate in conjoint sessions with Mary. Conjoint parent–child sessions generally have four purposes. First, they allow parents to demonstrate their ability to hear and talk about the trauma, all the while modeling appropriate coping. Second, they let children experience a sense of pride in sharing their narratives or books, further alleviating feelings of shame and distress associated with the trauma. Third, they enhance parent–child communication regarding the trauma, and clear up misunderstandings and areas of confusion. Finally, they lay the ground-work for therapeutic parent–child interactions to continue after formal therapy is finished.

A parent is emotionally ready to participate in conjoint sessions when the parent can effectively dispute upsetting thoughts and emotionally tolerate hearing the therapist share the child's trauma narrative in individual sessions. Before the conjoint parent–child sessions began, the therapist helped Linda process and overcome her anxieties about these sessions. Linda was worried that she might start crying during Mary's reading of the narrative, and she also thought that Mary would be angry at her for not knowing about the sexual abuse. The therapist helped Linda work through these emotions, while practicing how she wanted to respond to Mary. Linda identified helpful and supportive statements that she could make to Mary during their conjoint sessions. In her sessions with the therapist, Linda role-played responding to Mary in a supportive and validating way by using eye contact, asking nonjudgmental questions, and making accurate and reflective statements about Mary's narrative.

Mary's readiness to engage in sessions with her mother was assessed as well. It was suggested to Mary that it would be helpful to share her trauma narrative with her mother, so that she and her mother could talk together about what they had been working on in therapy. Mary stated that she felt nervous about sharing her narrative with her mother, because she didn't want her mother to cry. Mary was reassured that it was OK to cry when thinking about something sad that happened, and that her mother was prepared and was looking forward to hearing Mary read her narrative. Mary seemed reassured by that, and she also prepared questions she would ask her mother during the conjoint sessions. Mary particularly wanted to ask if her mom was upset with her for getting her father in trouble.

During the first conjoint session, Mary and Linda talked about child sexual abuse and domestic violence in general, as some children find it easier to speak generally about traumas before they are able to talk with their parents about their specific experiences. Mary and Linda communicated by playing a simple question and answer game in which the therapist asked Mary and Linda questions about child sexual abuse and domestic violence. Linda expressed a great deal of pride in Mary's ability to answer so many questions. The therapist played the role of a game show host, and both Linda and her daughter earned points for answering questions about child sexual abuse and domestic violence. This created a fun atmosphere that allowed both Linda and Mary to relax, despite the seriousness of the subject matter. In the next joint session, Mary read her entire trauma narrative. Linda praised her daughter and told her how impressed she was that Mary showed so much confidence in writing and reading her book. While Mary read her narrative, Linda also asked Mary open-ended, nonthreatening questions, such as "How did you decide to tell Grandma about what happened?" and "What did it feel like to write about the sexual abuse and the domestic violence?"

The therapist planned the conjoint sessions to end on a positive note, with Mary and Linda exchanging praise. Ideally, these exchanges incorporate praise that is specific (e.g., "Thank you for doing a great job cleaning the dishes last night"), so that children and parents share specific behaviors that they appreciate, as well as global (e.g., "I love you so much" or "I'm so proud to be your mom") reflecting feelings of unconditional love and/or pride. Mary praised her mother for helping her talk about the sexual abuse and for always believing in her, and Linda praised Mary for playing nicely with her brother in the waiting room, for working hard in therapy, and for being such a wonderful daughter and sister.

During the final conjoint sessions, mother and daughter reviewed their safety plan and practiced personal safety skills together. As part of the safety plan, Mary created a "contract" that she and her mother agreed to and signed; this listed safe places both inside and outside their home, as well as safe people (with their phone numbers) that Mary could talk to in case she needed help. Finally, Mary learned the differences between keeping surprises, which are OK, and keeping secrets, which are not OK. Mary and her mother practiced these skills in a conjoint session. They were given scenarios in which they practiced implementing the proposed safety plan.

Termination of Therapy

Upon completion of the planned course of therapy, the battery of standardized measures that Linda had completed before therapy was readministered. These measures were used to determine whether Mary's emotional and behavioral symptoms relating to the sexual abuse and domestic violence had diminished. The results showed that Mary's symptoms had diminished significantly, and that Linda was no longer reporting significant depressive symptomatology.

Finally, a graduation session was planned for Mary and her mother to celebrate their accomplishments in therapy. Mary received a graduation hat and graduation certificate, and both Linda and the therapist praised Mary for her hard work in therapy. Mary's grandmother and her 2-year-old brother joined the celebration at the end of the session, presenting Mary with a bunch of balloons to acknowledge her graduation as well. Although Linda anticipated that she would be facing significant challenges in the future, she seemed pleased to be celebrating her and Mary's success in completing this course of therapy, and was reassured by the therapist's openness to future contact in the form of calls or booster sessions. Linda even expressed interest in pursuing therapy for herself if she found herself feeling depressed or felt a need to work through her own feelings of loss and fears regarding future relationships.

CONCLUDING COMMENTS

TF-CBT seemed to be an effective, appropriate treatment model in this case, for several reasons. Mary and her mother seemed to benefit from the structure and active nature of this treatment approach. Mary was showing symptoms of posttraumatic stress, depression, shame, and self-blame, which this model directly targets. In addition, since Mary's mother was having difficulty managing her daughter's behavioral and emotional reactions, the parenting sessions were critical to Mary's recovery. This model works well as a form of short-term treatment with children who have experienced multiple traumas. Mary, in fact, was able to work through her feelings and thoughts related to her experiences of both domestic violence and sexual abuse. The model encourages education and development of skills to help the child and parent/caregiver gain feelings of mastery in coping with their specific traumatic situations, while also generalizing the application of these skills to other stressors. The work is done individually with the child and caregiver, until the caregiver becomes able to effectively support the child's healing process. In most cases, therapy ends with conjoint parent–child sessions. These sessions initially focus on the practicing of skills and open communication regarding trauma-related topics in general. The goals of the final conjoint sessions include sharing the child's trauma narrative, discussing trauma-related concerns, and reviewing safety skills with the parent and child together. Through her active participation in individual and conjoint sessions, Mary's mother became better prepared to respond to her daughter's trauma-related worries and potential difficulties, perhaps reducing the chances of symptom relapses. However, if difficulties arise, parents are encouraged to utilize the skills they learned in therapy and/or to use the therapist as a resource if they feel the need for guidance or "booster" sessions in the future.

The therapist was impressed with Mary's ability to be so open in such a short period of time, but not surprised, as TF-CBT has been found to be effective as a short-term model even with children who have experienced multiple traumas (Deblinger, Mannarino, Cohen, & Steer, 2006). The therapist did have to deal with her own reactions, particularly to the idea that this mother—despite suffering her own horrendous abuse by her husband for years, and subsequently finding out that he had also sexually abused her daughter—still had positive feelings for him. Although this was not completely unexpected, it was nonetheless still difficult for the therapist. Still, the therapist remained supportive and nonjudgmental, and in doing so established an excellent, trusting therapeutic relationship. This seemed to result in Linda's being very open to therapy for herself in the future, which in and of itself was an important outcome. In the meantime, Linda developed parenting and coping skills that would help her to face the inevitable challenges that lay ahead in dealing with the criminal and family court proceedings, as well as the day-to-day stressors of raising both her children as a single mom.

As an evidence-based treatment model, TF-CBT continues to be evaluated and applied to other populations—including children who have suffered traumatic grief, as well as other traumas (Cohen, Mannarino, & Knudsen, 2004). Moreover, it is important to note that TF-CBT will continue to evolve in response to ongoing research, which may further elucidate the critical therapy ingredients and the optimal doses of treatment needed to help children and their parents effectively heal in the aftermath of trauma.

Study Questions

1. What educational information about child sexual abuse and domestic violence might have been particularly important to share with Mary and her mother?
2. What do you believe gave the therapist in Mary's case confidence that this child would benefit from creating a book about herself and the trauma(s) she suffered?
3. What do you think the child learned from the experience of drawing, writing, and talking about the sexual abuse and violence experienced?
4. What factors may have influenced this mother to feel hesitant about using discipline procedures such as "time out" with her daughter?
5. What do you think will be the greatest challenges facing this family? What factors do you think will most influence Mary's prognosis?

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THERAPEUTIC RESOURCES FOR CHILDREN AND FAMILIES

Please Tell!: A Child's Story about Sexual Abuse
Author: Jessie (Sandra Hewitt)
Publisher: Hazelden Foundation
ISBN#: 0-8075-5319-0

A Safe Place to Live
Author: Michelle A. Harrison
Publisher: Kidsrights
ISBN#: 1-55798-701-7

The Hyena Who Lost Her Laugh: A Story about Changing Your Negative Thinking
Author: Denise Gilgannon
Publisher: Childswork/Childsplay
ISBN#: 1-58815-005-4

Let's Talk about Taking Care of You!: An Educational Book about Body Safety
Authors: Lori Stauffer & Esther Deblinger
Publisher: Hope for Families
ISBN#: 0-9676489-1-2

Where Did I Come From?
Author: Peter Mayle
Publisher: Kensington
ISBN#: 0-8184-0253-9

Today I Feel Silly and Other Moods That Make My Day
Author: Jamie Lee Curtis
Publisher: HarperCollins
ISBN#: 0-06-024560-3

Survivor's Journey: A Therapeutic Game for Working with Survivors of Sexual Abuse
Creator: Catherine Rohlfs Burke
Distributor: Kidsrights

Chapter 7

The Enduring Crisis of Divorce for Children and Their Parents

Judith P. Siegel

The crisis of families ruptured by divorce has become accepted as an inevitable consequence of contemporary life. Although it is commonly understood that half of all marriages will end in divorce, the prevalence of familial disruption is much higher when the numerous failed relationships of cohabitating couples with children are factored in. Gottman and Katz (1989) cite U.S. Bureau of the Census statistics showing the percentages of children living in nuclear families with two parents to be 56% of European American children, 38% of Hispanic American children, and 26% of African American children. This chapter explores the impact of marital problems on children, including problems that are present before divorce, and ones that may continue long after the legal papers have been signed.

Although the process of getting divorced typically unmasks and escalates accumulated resentments, children are affected by marital problems that predate the decision to end the relationship. Children form a template of intimacy from the dynamics they witness in their parents' marriage, and are affected when parents fail to respect or work cooperatively with each other (Siegel, 2000). All too often, marital therapy fails, and many "miserable" couples choose to endure ongoing marital discord rather than file for divorce (Heaton & Albrecht, 1991).

MISERABLE MARRIAGES

The actual prevalence of problematic marriages is difficult to calculate, as the presenting problem may not directly refer to marital stress. For example, women presenting with symptoms of depression often cite an unhappy or failing intimate relationship as the most frequent cause of their depression (Kung, 2000; Hafner, 1986). These women may choose individual therapy or psychopharmacology alone, masking the relationship dynamics that invariably affect both them and their children. Another symptom cluster that needs to be considered is parental substance dependence or abuse. Again, this problem may be camouflaged by denial or by therapy for the substance-using parent alone, leaving the marital issues and effects on the children out of clinical reach. When the prevalences of marital conflict, divorce, parental depression, and parental substance abuse are considered, it is clear that many families with children are experiencing profound stress. While not all children are adversely affected, there is an abundance of child casualties.

CHILDREN AND MARITAL CONFLICT

Although the adverse consequences of marital problems for children have long been clinically acknowledged, recent research studies have confirmed and clarified these consequences. Although not all children exposed to marital problems develop psychological problems, Cummings and Davies (1994) state that almost half the children exposed to severe marital hostility exhibit extreme behavior problems, and Beach (1995) declares that the rates of behavior problems among such children are roughly 600% greater than the rates of behavior problems in the general population. Cummings and Davies (1994) have addressed the adverse developmental consequences of growing up in an angry home, noting how background anger creates problems with affect regulation, emotional arousal, and disrupted attachment. Numerous studies confirm that children from high-conflict homes demonstrate an increased risk of social and relationship impairments, behavioral and emotional problems, and diminished academic performance (Allen, 1996; Grych & Fincham, 1990; O'Brien, Bahadur, Gee, Ballto, & Eber, 1997).

Effects of Various Conflict Dynamics on Children

Both the immediate and long-term consequences to children are most severe in families with spousal violence. The stigma of marital violence adds to the secrecy that too often prevents family members from making this situation public (Mills, 2003). Many couples fail to recognize that acts of physical aggression such as throwing household objects or slapping each other constitute physical violence. The National Family Violence Survey (cited in McNeal & Amato, 1998, p. 123) indicates that more than 3 million children witness interparental violence every year. A study conducted by Cassidy (1989) showed that of the 350 children interviewed, 337 had been exposed to parental verbal or emotional abuse, 121 to parents' intimidation of each other, and 93 to parental physical abuse. The prevalence of physical violence in parents may be as high as 40%, with many couples choosing to act out their violence in front of their children (McNeal & Amato, 1998; Wallerstein & Blakeslee, 1989).

Children who have witnessed parental violence are deeply affected. These effects often include inability to concentrate on schoolwork and strained peer relationships. Girls tend to become depressed or shut down, while boys are more likely to show an aggressive response. The rates of aggression, anxiety, depression, somatic complaints, school problems, and social difficulties in this population are summarized by Amato and Keith (1991), Cummings, Pellegrini, Notarious, and Cummings (1989), Gottman and Katz (1989), and Grych and Fincham (1990). Therapists may be less aware of the long-term adverse consequences than of the short-term effects. McNeal and Amato (1998) conducted a follow-up study of almost 500 young adults whose parents had been found to have an abusive relationship 10 years earlier. The authors found that the majority of these young adults were now in violent intimate relationships themselves. It is not surprising that the most potent predictor for adult violence is having grown up in a family where spousal violence was witnessed (Forero, 2005).

A less frequently explored dynamic is the family triangle that is created when a child inserts him- or herself between the parents in an effort to stop the parental conflict, or when one parent attempts to form a coalition with a child in which the other parent is excluded or blamed. Kerig (1995, 1999) has established a relationship between marital discord and these types of family triangulation. Kerig's research demonstrated that children in these kinds of families rated themselves higher in self-blame for causing or not preventing their parents' conflicts, and too frequently internalized problems. Many parents who are overwhelmed by relationship problems turn to their children as emotional caretakers and confidants, with damaging consequences to the children. Wells and Jones (1998) suggest that parentification of children contributes to the development of childhood defensive splitting. Children who become parental caretakers are burdened by responsibilities and worries that deprive them of the freedom to focus on their own developmental tasks and may leave them with faulty defensive mechanisms.

Children are also affected by marital dynamics that do not reach the level of physical violence or overt conflict. Children are highly reactive to hostile conflict styles that parents may express through nonverbal behavior or tone of voice (Allen, 1996; Barber, 1998). Katz and Gottman (1993) have also reported that children whose parents withdraw in conflict have heightened anger as well as problems regulating their emotions. Parents who are preoccupied by marital stress are not able to enjoy parenting. Mothers with marital problems are less playful with their babies, and overly involved and intrusive with older children (Belsky & Rovine, 1981). Tension and anger between parents may also spill over into the relationship parents have with their children. Parents in conflict are more critical of their children, and more likely to discipline in inconsistent ways (Harold, Fincham, Osborne, & Conger, 1997).

Effects of Parental Substance Abuse on Marriages and Children

Alcohol and illegal substances create problems not only for those who use them, but for their intimate partners and children. The relationship between marital dynamics and substance abuse is complex, for the abuse is often associated with preexisting marital stress or disruption, but also creates maladaptive and dysfunctional marital dynamics (Straussner, 1994). Amato and Previti (2003) have demonstrated that alcohol abuse is both a precipitant and a consequence of marital stress, spousal abuse, separation, and divorce. However, in addition to the indirect havoc that is created as a stressed marital relationship affects other family members, children are directly harmed by exposure to parental substance abuse (Copans, 2006).

Effects of Maternal Depression

Women in unhappy marriages are vulnerable to depression, and when seeking mental health treatment, they typically cite their marital problems as the source of their unhappiness. In a landmark study conducted well over two decades ago, Cohler, Gallant, Grunebaum, and Kaufman (1983) compared the children of mothers who had been hospitalized 4 years earlier for schizophrenia or depression with the children of well mothers. The children of depressed mothers fared the worst in social adjustment, school progress, and personal well-being. Depression interferes with a mother's ability to engage fully in the attachment process, leading to both immediate and long-term problems. Disruptions in marital stability that affect the mother's stamina and psychological well-being adversely influence the emotional tone of the parent–child relationship. Depressed mothers are more irritable, more preoccupied, and consequently more inconsistent in their responses to their children.

Effects of Parental Divorce on Children

There is presently a debate on the harm that divorce creates for children. Authors such as Wallerstein, Lewis, and Blakeslee (2000) describe longitudinal research with the grown children of divorce, who speak of the misery they have endured and of their own failed intimate relationships. Others, like Amato and Keith (1991), cite studies on young adults who have successfully adjusted to their parents' divorce. These authors suggest that the dynamics and conflict that precede the divorce may be the more powerful predictor of problems for the children.

Understanding the impact of divorce on a child is complex, as many events may be happening concurrently. Often divorce occurs because of infidelity, and children who are old enough to understand are profoundly affected by the knowledge of a parent's extramarital affair. Many divorces take place after years of destructive marital conflict, and the decision to divorce may escalate the acrimony and contempt between partners. Finally, divorce between the parents permanently changes the contact and connection between a child and the noncustodial parent; in effect, the child experiences loss of the parent as well as loss of the family unit. According to Neuman (1998), half of children from divorced homes haven't seen their noncustodial parent in the past year, and only one child in six has weekly contact.

Hostile Divorce as a Crisis

Children who are raised in homes with chronic parental discord suffer a distinct disadvantage. When the acrimony prevails beyond the divorce, the impact can be devastating. Parents who hate each other cannot help communicating this to the children. Their lack of respect and trust in each other erode the child's ability to identify with the strengths of both parents. This is especially so when the child's attempt to maintain a bond with both parents is perceived as a form of disloyalty. If a child's effort to love one parent is experienced as disloyalty to the other, the child is put in an impossible situation that threatens attachment and security. When intimate anger persists beyond the divorce, the struggle between parents to control resources often includes access to the child, especially when there have been failures to comply with child support. And when the conflict settles on the child as the only remaining tie to that union, the child cannot help blaming him- or herself as the cause of the enduring hostility.

THERAPEUTIC IMPLICATIONS

The Limits of Clinical Specialization

In the current era of clinical specialization, many therapists are trained to work with either children or their parents. Although child therapists and marital therapists alike recognize on a theoretical basis how profoundly children and their parents affect each other, the clinical work tends to focus on the client(s) in the room. Too often, the task of staying mindful of the needs and well-being of *all* family members complicates or obscures the treatment goals established for the individual client in treatment. Without a comfortable alliance and skilled interviewing, it is easy for parents to avoid revealing dynamics that often underlie or exacerbate a child's distress. It is equally challenging when a distressed parent turns to the child's therapist for guidance and support, thereby potentially compromising the child's claim to the therapist as his or her "own." Marital therapists often hear about stress and conflicts in the parenting realm, but typically use this information as indicators of the couple's dynamics in ways that shift the focus away from the child. This chapter presents a model of *inclusion*, where the child and parents are seen as equally important in unmasking and correcting the crisis of marital conflict, divorce, and postdivorce parenting.

Including the Parents in the Child's Therapy, and Vice Versa

Although child therapists are accustomed to interviewing parents of the children they are treating, the focus is usually on the child's developmental history, current situation, and relevant family situation. Authors such as Siskind (1997) and Webb (2003) have emphasized the importance of a therapeutic alliance in which parenting issues and other stressors can safely be discussed. I would add to that the importance of conducting an expanded interview with each parent—an interview that allows for discussion of their relationship.

Therapists such as Webb (2003) have argued for the end of the polarization that is inherent in either a child-centered or a family-centered approach to helping children. Therapists from both schools must acknowledge the combination of factors that lead to symptoms and problems, as well as the interplay of physiological, intrapsychic, and interpersonal dynamics that contribute to a child's well-being.

It is equally important for marital therapists to consider the individual well-being of children living in a home with a miserable or failed marriage. Partners who argue viciously in the therapist's office are probably doing the same at home, with little understanding of the impact of their hostility on their children. Marital therapists who learn about parenting disputes should pursue the well-being of the children, asking about their social adjustment, school performance, somatic complaints, and changes in mood or behavior. Often parents' awareness of the specific consequences of marital problems for child development may spark a new motivation for change, as partners who have given up improving their own intimate world may refuse to jeopardize their child's well-being.

Children of divorce are often tangled in the web of unresolved control struggles and bitterness from a failed relationship. The therapist's job involves working with both parents (and any stepparents) in order to help establish more constructive patterns of problem solving and decision making. At the same time, the therapist must develop a relationship with the child that allows his or her troubling issues and conflicts to emerge. In so doing, the therapist becomes an ally to the child, trying to help sort out those issues that have the potential for immediate resolution, and those that will require ongoing psychological adjustment and acceptance.

THE CASE OF PAUL, AGE 7

This case contains information from two families known to me, but it is typical of the situation faced by many postdivorce families.

Family Information

Paul, an only child, was referred with his parents for postdivorce therapy. The family had been in therapy before with a therapist who described their divorce as the most acrimonious and distasteful experience she had ever witnessed. The couple had divorced when Paul was 2 years old, following the discovery of an infidelity. His mother, Sara, was Bermudian, and moved back to her family of origin after the divorce. She returned to the United States each summer so that Paul could spend a month with his father, Phillip.

After 5 years, Sara decided to move back to the States. By that time, Phillip had remarried and relocated to the suburbs with his new wife, Ann; her 8-year-old daughter from a previous marriage, Jenna; and the couple's infant son. Sara and Paul found a home in a neighboring suburb, and Paul began to spend alternate weekends with his father and new blended family. Within weeks, unresolved control struggles and anger between Sara and Phillip surfaced, and Paul's behavior deteriorated. It was Paul's challenge to create a place for himself within a new blended family, while simultaneously adjusting to the loss of his extended family in Bermuda and his familiar world. The tension between his parents did not help, and after 8 months of conflict and struggles, the family decided to seek therapy for Paul.

Initial Contacts

Paul was an attractive but somewhat suspicious 7-year-old child. At the time I first met him, he was experiencing troubles in school, where he was described as somewhat headstrong and often disobedient. His school performance was low-average, which led Phillip to suspect that Paul had learning problems. Sara refused to have Paul tested, and was insistent that the behavior problems described by the teacher were more indicative of an impatient, rigid instructor than a playful, curious child. The parents bickered about child care arrangements and other child-related decisions, such as after-school activities that were Phillip's financial responsibility. The two parents ran their homes very differently, with Sara more comfortable with extended bedtime hours and free play. Phillip strongly disapproved of the time Paul spent in front of the TV or playing with his PlayStation.

When I first met the family, one problem that both parents agreed on was Paul's reluctance to spend time in his father's home. Sara described Paul as being "hyper" and "completely stressed out" after a weekend at this father's home. Phillip described his frustration with Paul's need to call his mother to intervene each time that he or his wife, Ann, tried to impose a family rule. Paul also fought with Ann's daughter, Jenna, who was adjusting to sharing her mother with yet another sibling. Paul exhibited sleep difficulties and was afraid to be alone in his designated bedroom at his father's home. On occasion Paul had sleep terrors and would wake up screaming or lashing out at anyone who tried to comfort him.

Treatment Plan

The therapy involved interventions with different constellations of family members. A session with Paul alone would be followed by a session with Paul, Phillip, and Ann. Paul would then be seen alone again, with a subsequent session with Paul and Sara. There were times that I saw each set of parents alone, and, after 4 months of work, two sessions with all three adults.

Initial Play Sessions

In his play sessions, Paul remained suspicious of me but engaged quickly in play with Legos, building futuristic vehicles that turned into dragons and quickly back into space ships. Paul's creations were all balanced and functional, and he was able to explain where the guns were kept, as well as how quickly the machines could fly. Paul would purposefully test any limit I set for him, and especially resisted cleanup as our time together ended. Paul was initially guarded when I asked him questions about school, but was more willing to talk about his parents. In our first session alone, I asked Paul if he thought his parents liked each other. Paul quickly told me that they hated each other. He said that his father was always calling his mother "stupid," and all of her ideas "crazy." His mother would roll her eyes when Paul told her about events at his father's home, and would confide in him that his father hadn't changed one bit.

What concerned me the most about Paul was his chameleon quality. In the session with his mother, he was affectionate and needy of her attention, wanting to sit on her lap and have her comment on all of his Legos creations. As Sara started to complain about Philip's rigidity regarding schedule changes and house rules, she would encourage Paul to talk about these concerns in ways that seemed to be egging him on. Paul would describe incidents that had occurred over the past week, stopping to ask his mother to guide him when he "forgot." Sara stated openly that Paul simply didn't want to stay at his father's home, and that it was an ordeal to have to get him ready on alternate weekends.

In sessions with his father, Paul seemed relaxed but attention-seeking. He spoke about the fun he had had catching frogs, and the things he wanted to do the next time he was at his dad's home. With my prompting, Paul was able to talk about not liking to sleep alone, and seemed relieved when his father and Ann agreed to set up a sleeping bag by their bedroom door in case he needed to use it. He also asked if he could sleep in the twin bed in Jenna's room, and seemed pleased with that option.

Overview

Paul struck me as living in two worlds, where he prospered by reading how to please each parent and act accordingly. His behavior was more infantile with his mother, and in his sessions with her, he seemed to enjoy describing how terrible his father was to a confirming audience. With his father, he was more the humorous child, avoiding problem areas or discussion of feelings. If his father mentioned Sara in a disparaging tone, Paul would noticeably stiffen and withdraw.

Session 5 (with Paul)

Content of Session	*Rationale/Analysis*
(*Paul pulls out a Legos creation and seems pleased that it is still the way he remembers it. He then splits it in half and starts building a new model.*)	
THERAPIST: I have seen you with each of your parents now, and I can see how hard it is for you.	I am directing our conversation and hoping that Paul will be comfortable to join in. He isn't, and I follow the play.

PAUL: This machine is the fastest one I've ever made, and it can get to the moon in 10 days.	
T: What will it do once it gets there?	
P: It can do anything it wants to.	
T: Is that like you at your dad's home?	I'm aware of the different set of rules, and hope that Paul will be interested in talking about that.
P: No, I can't do anything there. He won't let me play with my PlayStation games, because he says they're too old for me. My mom knows that I can play with them just fine, but my dad won't listen.	
T: Your mom understands you better than your dad.	
P: Right. (*The new machine gets tested by flying from the window ledge to the floor, where it loses several pieces.*)	Paul seems absorbed in the play and uninterested in our talk.
T: The machine crashed.	
P: I can fix it. I can fix everything.	
T: You know how to take care of things.	
P: (*Empowered*) Yup.	
T: I thought it was hard last week when your dad didn't say good things about your mom.	
P: I hate when he does that.	Paul is opening up more to me and sharing some of his more private feelings.
T: That is one thing I can help you change. We can talk about it in our next session with him and Ann.	
P: OK.	
T: Do you need help fixing it when your mom says not-nice things about your father?	
P: She is always right.	This confirms my sense of Paul's need to protect Sara.
T: Your mom knows what games you should be allowed to play with.	
P: Yup, and not sleep alone either.	
T: Are you sleeping in Jenna's room now?	
P: Yes, but I have to let her win our fights, or she says I can't sleep there any more.	It seems that Paul has to pay a price. Jenna is older, and she is clearly the queen when it comes to settling their disputes.
T: Does your dad or Ann know?	
P: I try to tell them, but they don't get it. They stick up for her.	
T: They stick up for Jenna, but not for you.	

P: This machine is better than new. Do you want to see if it is the fastest one I ever made?	Paul has opened up enough. He retreats to his play, and I follow.
T: Sure, you build the best machines I've ever seen.	

Session 6 (with Sara)

Content of Session	*Rationale/Analysis*
THERAPIST: Sara, I'm worried about Paul needing to protect you.	
SARA: That's nonsense. I've got everything under control.	Sara has a slightly cocky edge to her. She seems to resent being in therapy.
T: I believe that, but perhaps Paul notices things or remembers a time when that wasn't the case.	
S: He was too young. By the time I moved home, he was still a toddler. I've always believed in picking yourself up and starting fresh.	
T: It's hard to explain a boy's love for his mother.	When Sara trusts that I truly have Paul's interest at heart, she is able to tolerate what I am saying.
S: (*Softening*) He's been through a lot, but he's a really great kid.	
T: I guess it's hard on him having to get used to two homes and two sets of rules. Why do you suppose it's so difficult for you and Phillip to talk about these things?	
S: He is highly critical of me and disapproves of everything I do, as a mother or otherwise. He's also cheap, and at the end of the day, it all comes down to the dollar!	It must have been very different when she had total control over all of Paul's care and lived a thousand miles away.
T: I'm sure this is hard on you as well, but I would love for you and Phillip and Ann to be able to sit in the same room and work out some of these issues. I think that you hear only one side of the story, and it's from a child's perspective.	
S: I doubt that Phillip would ever agree to that.	They hate each other so much!
T: In the long run, it makes more sense to be able to work things out together than to have to rely on a therapist to intervene.	Sara is not comfortable being in therapy. I acknowledge her wish for independence.

S: Yes, that's what I think too.	
T: What are your thoughts on Paul's reluctance to visit with his dad?	
S: Well, he is hard-headed, and not at all sensitive. I don't think Paul feels very safe there.	
T: And he calls you every time he has an issue with his father or Ann? (*Long silence*) Sara, what if Paul wants to make you feel good about being his mom, and lets you know how much he chooses you over his father in order to make sure you will never doubt his love?	
S: He doesn't need to do that.	
T: I wonder what might change if you stopped him every time the subject of his dad's differences came up? What if you simply commented on Paul's problem-solving skills, and what a good job he's doing at fixing things?	
S: I really don't think that's the issue here.	Sara wants me to support her against Phillip, and is not ready to move that quickly.
T: I worry that Paul is split in two very different worlds. It's hard enough for him to get used to two sets of house rules, but it would be impossible for him if getting along with his dad meant hurting you.	
S: I don't want him to think that. I can try.	Sara has a very deep love for her son and is committed to his well-being.

Some Progress and a Major Setback

After months of sessions with different sets of family members as described earlier, the three adults were able to meet together to share concerns and strategies. My stance was to validate the wisdom and experience of each parent (and Ann), so that they could collaborate from a respectful position. Any critical comments or references to the past were quickly challenged by me, and differences that might have created polarized positions were reframed as ways to balance both sides of a problem. When each parent was recognized as bringing something of value that could be acknowledged by the other, they were less defensive. Strategies for bedtime, limit setting, and discipline were openly explored, with joint problem solving. Not surprisingly, Paul's behavior in school and his night terrors began to improve.

Due to the parents' financial concerns, I stopped weekly sessions at this point and saw Paul and/or his parents on a monthly basis. The family functioned cooperatively for 10 months, during which time Paul's relationship with his new half-brother became an important addition to his life. The family terminated sessions for the summer, but kept me informed of Paul's situation through e-mail. I was aware that Paul had spent 2 weeks in Bermuda with his extended family and then vacationed with his father. All appeared to be going smoothly. However, shortly after that vacation, I received a frantic phone call from Sara. Apparently Paul and Jenna had fought in the car, and when Paul returned home he told Sara that Ann had turned around from the front seat and slapped him. Although I suggested that the three adults meet with me to sort this out, Sara refused, and she informed me that she had called her lawyer. She stated that she could not accept physical violence and felt compelled to protect her son. Upon her lawyer's advice, she had filed abuse charges with child protective services (CPS). Phillip and Ann were devastated. According to Ann, the two children had been fighting in the car and were hurting each other. Ann had turned around to separate the two kids while Phillip pulled off the road. She swore that neither parent had done anything to the children beyond using their strength to separate them. Paul had been hit by Jenna, just as Jenna had received punches from Paul.

CPS conducted a full investigation. Sara had filed for an order of protection against Ann, and requested that Paul's contact with his father be limited to supervised visits. The court upheld this request pending the CPS findings. Ann was furious at Sara for going to court without even hearing her side of the story, and angry at the expense of retaining lawyers. Phillip tried to get Paul to deny the story, which caused Paul not to want to see his father, even in supervised visits.

First Session with Paul after Court Involvement

Content of Session	*Rationale/Analysis*
THERAPIST: I hear a lot has been going on this month.	
PAUL: My mom says I don't have to talk about it with anyone. (*Paul starts playing with the Legos, but is noticeably withdrawn. He is engaged in making a vehicle, but not playing with it.*)	
T: Is it that bad? (*Paul remains silent.*) You sure are in a tough position.	Paul avoids eye contact. I feel so sad for him.
P: Yup. (*Long silence*)	I stay with the silence for a few minutes, hoping the previous work that has occurred in the room will help him recover some trust for me.
T: We've solved lots of other problems; we can solve this one too.	
P: Nope, they're all mad at me. (*Paul starts to fly the Legos vehicle in an angry way, ramming it into an ottoman.*)	

T: Well, we can figure out how to change that.	I am tempted to ask Paul what really happened, but I know this would be too threatening. I want to take him past the problem to a solution.
P: Nope, they all think this is my fault.	
T: Well, sometimes bad things happen, but that doesn't mean they can't be fixed.	
P: Like what?	For the first time, Paul is fully engaged and is making eye contact. I am relieved, but sense how fragile this is. Paul returns to the vehicle and withdraws. He seems uninterested. I am concerned that he is depressed.
T: Haven't you ever been hurt before, but you know it was an accident? (*Silence*) Didn't you tell me that your mom got you a kitten when you moved here?	
P: Yeah, Pepper.	
T: And didn't Pepper scratch you one day?	
P: Yeah, and I threw him on the couch!	Paul's response is aggressive.
T: Yes, you got mad back after he hurt you.	
P: Yeah, I was bleeding!	Again, a focus on the damage.
T: But after a while, it didn't hurt any more.	
P: Yeah, we're friends now.	
T: That's the way it can be between you and Ann and you and your dad.	
P: This is different. You can't fix this.	Paul says this with defiance.
T: You made friends again with Pepper because you love Pepper. Pepper hurt you, but in your heart, you knew that Pepper didn't want to lose you. Pepper loves you too.	
P: I don't know what to tell them.	Smart kid; he gets it immediately.
T: We can do it together. (*Long silence*)	I sit out the silence. Paul has to want this, or it won't work.
P: I don't want to talk about it unless you're there.	
T: We can make a rule. The new rule is that if you want everyone to stop talking about it, you get to say something.	
P: Like what?	
T: Like "I don't want to talk about it any more right now." Let's try this now and see how it works. Do you want to tell me about your trip to Bermuda?	
P: I don't want to talk about it any more right now!!	

Further Work with the Adults

The purposes of my work over the following 2 months were to help the family sustain connections during the court investigation and to help Phillip find a way to mend his relationship with his son. I told Phillip that Paul was caught between two stories and was not strong enough to undo what was in place. I asked him to focus instead on the future, with the primary goal of reestablishing a trusting bond with his son. I shared the story of Pepper's scratch, and I asked Phillip if he could join in that metaphor as an opportunity for moving on. I asked him to understand how frightened Paul was, and how he himself needed to respect Paul's pace. I encouraged Phillip to respect Paul's ability to end conversations, and to move ahead with reassurance that Paul would not be punished. Phillip seemed relieved and agreed to respect Paul's right to "not talk about it any more right now."

I then asked to speak to Ann alone, as her mending and cooperation were vital. As I expected, Ann was resentful and bitter that a feud between her husband and his ex-wife had spilled over to her. CPS had closed the case for lack of evidence, but the order of protection had stayed in place until the court hearing. Ann resented the time and money that was being spent on lawyers and court-appointed supervisors, and she spoke frankly about her reluctance ever to discipline Paul again. However, she was able to relate to her husband's fear of losing his son, and able to find a way to forgive Paul, while resenting Sara.

I also had two sessions with Sara, who was initially defensive and hostile. She claimed that I had told her to call CPS, and that she had done what any mother would do when a child reported physical abuse. I told Sara that there certainly was a part of Paul that didn't feel safe, and that he had been hurt that day, but that the actual story might have gotten mixed up by the time he got home. I wondered why she didn't have any confidence in the talking format we had created and the option of checking out the other adults' perspectives before she took action. Sara was insistent that Phillip and Ann would have lied, and that it was her job to take her son's complaints seriously. I asked her if she thought her life would be easier if Phillip was not active in Paul's life, and she thought it might be. In previous sessions, Sara had been reluctant to speak about her own childhood, saying that she wasn't a strong believer in all that stuff about the past. However, I knew that Sara's parents had been divorced when Sara was young, and that she had not maintained a close relationship with her father. I asked Sara if she could think about her own childhood situation and what she truly wanted for Paul. Sara was annoyed at my references to her childhood; she claimed that the only reason she had returned to the States was so that Paul would have a chance to have a good relationship with his father, and that she certainly didn't want to get blamed for the opposite.

First Session with Sara after Court Involvement

Content of Session	*Rationale/Analysis*
THERAPIST: Sara, what if at the end of this we never know the total truth of what happened	

in the car? I have my own thoughts on what might have been going on for Paul then.

SARA: Go on.

T: I was just thinking how you had spent a wonderful time in Bermuda. Paul hadn't been back for a year. That must have been an emotional experience for both of you.

S: It was wonderful, just like we never left. But vacations do come to an end.

T: Yes, but you have more control over the decision to stay or go. Paul just gets moved.

S: I see your point.

T: I also wonder if there was a tiny part of you that felt sad saying goodbye or homesick. All of that can get complicated for a sensitive boy. On some level, Paul probably thinks the only reason you left Bermuda was so that he could have a relationship with his father.

S: Are you suggesting that I put him up to this?

T: Of course not. But I'd like to use this experience as a learning opportunity for all of us. I think that Paul's waters run deep. What if it was too difficult to be home, where you both have been so happy, and then to go on a vacation without you? You must have been just a little sad to see him go, and I suspect he was sad as well. What if it was just too much for Paul?

Sara is getting uncomfortable. I have clearly gone too far, and Sara feels blamed. I need to be more careful here.

S: Well, whatever happened, Paul doesn't want to go back to Phillip's house.

T: Would you want to face that family? Imagine what it would be like to face them on his own.

I am trying to help Sara think about Paul's experience from his point of view. There is a part of her that is moving with possibility, but another part that is getting annoyed at me.

S: I don't know what you want me to do. First you say that Paul is too influenced by me, and now you want me to influence him.

I feel Sara's anger. She is still feeling blamed by me.

T: I see what you're saying. I guess that for me, feelings that don't have words are more dangerous. Once they can be openly talked about, it's easier to sort it all out. When feelings are

I wonder if she can hear any of this.

contagious and both people feel something they can't talk about, things get mixed up. When it's out in the open, it's more like problem solving, like two people putting their heads together. I know that you do that so well with Paul.

S: I've just told him that he doesn't need to do anything that he doesn't want to. I'm going to let the court settle this.

T: You sense his fear, and you're trying to keep him safe.

S: Exactly.

T: What if you help him look at living in the States, and how important it is to make up with Ann and Jenna? I think sometimes he needs to feel your commitment to this arrangement.

S: So you think we're just supposed to go on like this never happened?

Sara is struggling with this.

T: The lawyers are definitely in the picture right now, but it's going to be over sooner or later, and I'd like to make sure that something like this doesn't happen again. I think that you and Phillip and Ann have to trust each other to do the best that you can do for someone you all love. Perhaps the three of you need to talk more about discipline and how you want things dealt with.

S: Well, Paul doesn't want to ever sleep at Phillip's house again. We're not even close to working on this.

T: Perhaps we can start by meeting together.

S: We can't when there's an order of protection.

The Court Hearing and Its Effects

Unfortunately, the order of protection was kept in place for another month until the court hearing. CPS had closed the case, finding no indication of abuse. Both parents gave their permission for me to present my assessment and recommendations, which I shared with each in session before I sent a written report. Ultimately, the court-appointed child guardian asked the judge to provide a transition time, and recommended that supervised visits continue for another 6 weeks until the family was fully prepared to resume normal visitation. Phillip was furious at me for introducing the idea that Paul didn't feel completely safe to the law guardian, and was outraged that he had to continue to pay for supervised visitation after CPS had closed the case. He was bitter at the legal system and mistrustful of Sara, claiming that she had ruined his life for 4 months and could do it again any time she chose. The extension of the supervised visitation was a final blow to Phillip, and his initial response was to choose no visitation with his son rather than play this absurd game. Although I did manage to help Phillip contain his anger and work within the system, he was somewhat guarded after he began to see me as an expert who could be influential in a court battle, rather than as a family therapist who was available to him without any strings attached.

Conclusion of the Case

My immediate goals over the following months were to help empower Paul to communicate when he didn't feel safe, and to turn to the appropriate adult to help him solve the problem at hand. I also worked to help Sara become more aware of how attuned Paul was to her feelings, and how he often joined her in ways that neither spoke openly about. I had a session with Paul, Phillip, and Ann to facilitate forgiveness and to engage in some problem solving about the fights between Paul and Jenna. Throughout my work, I was acutely aware of the differences in perspective and the mistrust that permeated the postdivorce relationship and parenting. Blow and Daniel (2002) describe the confusion that is created when parents maintain competing versions of the truth and battle to have their own perspective prevail. Rather than allow Paul to be swept into a superficial compliance, I challenged the parents to co-construct a perspective where Paul's needs and feelings could be the central focus.

Within 3 months, the family life returned to "normal." Unfortunately, the legal bills strained this family's already stressed financial situation, and the parents decided to have Paul start play therapy with a therapist covered by the family's insurance. For the following 8 months, Paul came to see me every other month to ensure that things were truly going well. As in most cases of postdivorce therapy, the family members were encouraged to use me as a resource if they needed help solving any problems that emerged.

Study Questions

1. Discuss the ways that marital conflict and unhappiness can affect the children in a family.
2. Why do you think triangulation is so common in divorce situations?
3. What are the ethical, legal, and clinical issues that arise when a child's therapist is asked to provide information to law guardians and others who are making legal decisions regarding custody and visitation?
4. How can therapists empower children caught in marital/divorce disputes?

Role-Play Exercise

1. Play out a session with two resentful, critical ex-spouses. How can the therapist help them accept their differences in a way that deescalates tension and defensive postures?

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Chapter 8

The Crisis of Adoption Disruption and Dissolution

Pamela S. Bruning

Adoption of a child into a family is an act celebrated and embraced by the whole community. Whether the adoption is domestic or international, or whether a baby or an older child is involved, the shared joyful feelings surround the family as they bring the child home. Many of these placements lead to happiness, wellness, and security for the children and families involved. However, a small percentage of these adoptions will lead to distress and further loss for the children and family members, who had hoped for a very different outcome. These troubled adoptions—the ones that do not last—constitute the focus of this chapter.

The motivation and circumstances that lead to adoption are varied. Whatever the circumstances, everyone entering into an adoptive placement does so with the belief that it is a lifelong commitment. When circumstances cause that commitment to be broken or reversed, it is referred to as "disruption" or "dissolution."

The Child Welfare Information Gateway (2004) defines "disruption" and "dissolution" as follows:

> The term *disruption* is used to describe an adoption process that ends after the child is placed in an adoptive home and **before** the adoption is legally finalized, resulting in the child's return to (or entry into) foster care or placement with new adoptive parents. . . .
>
> The term *dissolution* is used to describe an adoption that ends **after** it is legally finalized, resulting in the child's return to (or entry into) foster care or placement with new adoptive parents. (p. 1)

Although there is a distinct difference between "adoption disruption" and adoption "dissolution," much of the literature and many research studies use the terms interchangeably. "Disruption" is the more common term and is often used to refer to both categories.

In the 1970s I worked in New York City, assisting Kay Donley Ziegler—a pioneer in the area of adoption disruption—at New York Spaulding for Children, a special-needs adoption agency. Our charge was to demonstrate that all children are adoptable. What we found was that all children are placeable; the challenge came in keeping them placed. Critical to this goal was the availability of skilled postplacement services, ideally before difficulties reached crisis proportions. New York Spaulding was a member of Family Builders Network, an organization formed by the Child Welfare League of America. The focus of the network was to promote permanency for all children, including the development of a tracking system to alleviate the problem of losing children in the system. It was this experience that sparked my interest in attachment and adoption, which later led to the development of my private practice dedicated to the treatment of trauma and adoption-related issues.

This chapter first discusses the rates of adoption disruption and dissolution, as well as the dynamics of children and families that result in the disruption or dissolution of their adoptive placements. Treatment of the child and family is then addressed, including the appropriateness and role of play therapy in healing the crisis of loss, achieving a sense of closure, and allowing the child and family to move on.

ADOPTION DISRUPTION AND DISSOLUTION: RATES AND CONTRIBUTING FACTORS

Disruption

The Child Welfare Information Gateway (2004) provides the following information on adoption disruption.

> **How many adoptions disrupt?**
>
> Individual studies of different populations throughout the United States consistently report disruption rates that range from about 10 to 25 percent—depending on the population studied, the duration of the study, and geographic or other factors (Goerge, Howard, Yu, & Radomsky, 1997; Festinger, 2002; Festinger, [2005]). . . .
>
> **Why do adoptions disrupt?**
>
> Although specific causes of disruption may vary with each situation, the primary factors (correlates) in disruptions are well documented. Several studies have shown that the rate of disruption increases with the age of the child. Other correlates include the number of placements the child experienced while in foster care, the behavioral and emotional needs of the child, and agency staff turnover (Barth & Miller, 2000;

> Berry, 1997; Groza & Rosenberg, 2001; Festinger, 2001; Smith & Howard, 1999). Research suggests that disruption is probably less likely when services have been provided (Goerge et al., 1997), although no direct links have been shown between particular services and disruption rates. (pp. 1–2)

The Encyclopedia of Adoption's website (see Adamec & Pierce, 2000) refers to Trudy Festinger's study, described in her book *Necessary Risk: A Study of Adoptions and Disrupted Adoptive Placements* (Festinger, 1986). The children studied were in the New York City area, all over 6 years old, with an average age of 10 years, 2 months. The disruption rate for adopted children 6–10 years of age was 8%, while the rate for children 11 and older was 16%. Children placed with their own siblings were disrupted at a much lower rate than children placed alone: Festinger found a 5.6% disruption rate with children placed with their siblings, contrasted to a 10.7% disruption rate for children placed alone. Children who were placed alone *and* who had siblings living elsewhere had a very high rate of disruption (20.6%).

A study by Richard P. Barth and Marianne Berry (1988) found no significant level of disruption among homes with nonadopted biological children already in the home. But other researchers have found that when an adopted child is having severe conflicts with children already in the home, this can lead to a disruption.

If a child is a product of a previously disrupted adoption, the risk of another disruption is much higher. A University of Southern Maine study found that 34% of the disrupted children had previous disruptions, compared to 12% for the successful placements (Partridge, Hornby, & McDonald, 1986).

Prior sexual abuse constitutes yet another major factor leading to disruption. Some experts say that the disruption rate in these cases is as high as 86%. Sexually abused children are more likely to present behaviors that threaten any placement: They tend to be more sexual with both children and adults, and that behavior reflects their anger associated with their own abuse.

In the University of Southern Maine study (Partridge et al., 1986) 86% of the disrupted adoptions involved children who had suffered physical abuse, compared to 58% of the nondisrupted adoptions. Overall, 90% of the disrupted adoptions involved children who had been abandoned or neglected, and 64% had suffered emotional abuse.

Dissolution

The Child Welfare Information Gateway (2004) provides the following information on adoption dissolution.

> **How many adoptions dissolve?**
>
> Accurate data on dissolutions are difficult to obtain, because at the time of legal adoption, a child's records may be closed, first and last names and social security number may be changed, and other identifying information may be modified. The

> Federal Adoption and Foster Care Analysis and Reporting System (AFCARS) includes two data elements to show previous adoption for a child in foster care—whether the child was ever previously adopted and, if so, age at adoption—but those data are reported only for children in public foster care and do not capture adoption dissolution if the children do not come to the attention of the public child welfare system. Also, some researchers have observed that these data are inconsistently reported by the States. Studies consistently report that only a small percentage of completed adoptions dissolve—probably between 1 and 10 percent. . . .
>
> **Why do adoptions dissolve?**
>
> One study found that the rate of dissolution increased with the age of the child at adoption and was more common for male or non-Hispanic children (Goerge et al., 1997). Festinger (2002) reported that although dissolution is rare, families who adopt children with special needs from foster care undergo enormous struggles and face serious barriers to obtaining needed services. The two barriers most often mentioned by adoptive families were lack of information about where to go for services and the cost of services (Festinger, 2002; Soderlund, Epstein, Quinn, Cumblad, & Petersen, 1995). (pp. 2–3)

Despite the importance of statistics, they do not represent the human dimension. Whether they refer to war casualties or to humans suffering from natural disasters or other crises/traumas, numbers alone mean little until a personal story brings them to life. The following case illustrates a complex international adoption of a sibling group.

THE CASE OF AN INTERNATIONAL ADOPTION

Mr. and Mrs. Swift, a childless American couple in their mid-30s, adopted three siblings from a Russian orphanage. The children were 6, 8, and 10 years of age at the time of placement. Little was known or shared about their early childhood. They were born to a mother who was a poor farm worker, and who was also known to drink heavily and work as a prostitute. Each child had a different father. As toddlers, they lived in a small apartment where they witnessed their mother's activities. Due to neglect, the three children entered an orphanage when they were 4, 6, and 8 years old. They remained there for 2 years until their adoption.

After coming to the United States, the children quickly learned English and were able to share some of their own history. They had experienced extensive trauma in addition to neglect: They had not only witnessed their mother's sexual encounters, but had been sexually abused themselves. After the initial adjustment period, all three children began presenting behaviors that were symptomatic of extreme emotional disturbance. Unless constantly supervised, they sexually acted out. They were responsible for the deaths of numerous animals on their adoptive parents' farm, including sheep and a horse. They were also manipulative and dishonest in the community, often lying and stealing from neighbors and other children at school. They soon realized that they not only could split their adoptive parents, but also could place their parents at odds with the school personnel. For example, they would eat their snack and lunch on the way to school, reporting to their teachers that their parents were sending them with neither. If they had been reprimanded or if firm limits were set at home, they would report abuse to their teachers. The teachers then reported the accusations to the local child welfare agency, who took the children at their word and began threatening to bring charges against the Swifts.

The family lived in a remote area where few supportive services were available. There were no professionals in their area who understood the dynamics of traumatized, unattached children. It took several years for the school personnel to begin to understand the degree of damage done to these children prior to their placement, or the ways it was manifesting itself in the family and the community. Nor could extended family members appreciate the depth of the Swifts' distress. People were well-meaning in their caring about children who had experienced such an unfortunate childhood. However, sympathy/empathy did not cloud the reality of the ongoing crisis, where everyone in the family was in a state of disharmony.

Despite the good intentions of the Swifts and their endless efforts at providing corrective and nurturing experiences for the children, all three children eventually required psychiatric hospitalization and placement in residential treatment. They would periodically return home, but were never able to return home permanently. This case, like many others, would have been a case of adoption dissolution had the Swifts' state supported legally dissolving adoptions. In order to dissolve their adoption, the Swifts would have had to plead guilty to neglect. They were both employed in fields where a neglect finding would have damaged them professionally.

Parents such as the Swifts, who are raising children whose behavior reflects their traumatic backgrounds, need understanding, support, and information. I have found it helpful to give parents a handout that spells out the potential pitfalls. The title of the handout is *Post Traumatic Stress (PTS) in Families with Attachment Disordered Children* (National Adoption Center, 1997). An excerpt from this handout follows.

> Welcome to the war zone! This war is undeclared. This war is a war for which you are not prepared. This is a war for which there is no basic training. This is a war which is invisible to the world around you. This is a war for the heart and soul of your child. This is a war to keep your sanity. . . .
>
> - Your child believes that the world is unsafe, that you are unloving, that s/he is unlovable, that s/he must control at all costs in order to survive.
> - Your child believes "you are the enemy", and that if you get too close, the pain will be unbearable.
> - You believe that the world is full of opportunities, that you are loving and want what is best for your child, that freedom from control requires self-

> discipline. You believe there is happiness and fulfillment in close personal relationships, and that the way for your child to survive is to allow you to love, nurture and train her/him. You want only to soothe away your child's pain. Most wars are mutually antagonistic. In this war, your child uses hate and rage to push you away. You, however, love your child. This love must remain strong "against all odds", if you are to win the war. Parents of children with Attachment Disorders are living a chronic stress that threatens their well-being. This ongoing stress can be more devastating than a major catastrophic experience. (p. 1)

CHALLENGING ISSUES IN ADOPTION

Whether adopting from within or outside of foster care, many families are simply unprepared for the severity of the damage to their adopted children or for how that will manifest itself in their daily lives. The impact of these children can be devastating, and many of these families' lives are changed forever, as the Swifts' case illustrates. The following discussion presents some of the issues that can undermine adoptive placements.

- *The child's inability to develop trust in the adoptive parents or to engage in a reciprocal relationship*. Even when adoptive parents expect a difficult adjustment period, they may live with hope that the quality of the relationship will improve in time. When extreme stressors persist, the adoptive parents give until they are depleted. With little or no positive feedback from the child, they become emotionally bankrupt and begin to resent their situation. They may eventually feel unsafe because of the child's aggression, and this creates worries that they cannot continue to parent the adopted child.
- *Lack of information about the child's history and family background*. Many parents adopt children without full disclosure of their histories. In some cases of international adoption, for example, children's histories are misrepresented to make them more desirable. Sometimes the adoptive parents are told that the children have spent their entire childhood in an orphanage, only to learn later that they resided with their biological parents until shortly before the placement; in other cases negative information about the biological parents or the children themselves may be suppressed. Had the adoptive parents been privy to the withheld or minimized information, they might have chosen not to pursue the placement. Through the efforts of foster and adoptive parents and groups, there is pressure now on agencies to disclose *all* information. Failure to do so has been the basis of court actions to obtain necessary funding for services or to dissolve some adoptions. This was previously considered an issue specific to the adoption of older children, but because international adoptions have been shown to include children damaged at an early age through abuse, neglect, substance abuse *in utero*, and institutionalization, the need for full disclosure is now viewed as universal.

- *Despite education and preparation, the adoptive parents' belief that their placement will be different.* Although prospective adoptive parents may attend group sessions to prepare them for adoption and the possible trouble spots, they may still deny that trouble will occur between them and their adopted child. The desire to parent through adoption clouds their ability to process negative information or to believe that the placement could be *that* challenging. Complaints are sometimes made by the parents that they were not prepared by the agency. The reality is usually that the material was presented, but not fully believed.
- *Insufficient postplacement support.* Parents are often left without adequate postplacement support. They must deal with behaviors and issues that are unfamiliar to them or beyond their scope of expertise. They may have been trained by a social worker prior to the placement, but nothing can adequately prepare the adoptive parents of a child with special needs for the day-to-day stressors they will encounter. A common dilemma for adoptive parents is obtaining necessary medical, dental, and psychological care. Although the family may receive an adoption subsidy and the child may qualify for Medicaid, relatively few providers accept Medicaid. Finding the right fit with a provider may also be seriously limited by availability, financial issues, and geographical proximity. The cost to any agency or system for providing the needed services to support these placements is prohibitive. But children with a history of trauma, neglect, and abuse present serious difficulties that may require group care, hospitalization, and/or residential treatment.
- *Lack of skilled, knowledgeable social workers and therapists.* Any professional providing services to adoptive families should be well versed in trauma theory. They need to know the effects trauma has on brain development in early childhood, and how these manifest themselves physically, emotionally, and spiritually. They also need to know about bonding and attachment theory, and about the best ways to treat attachment disorders. In addition, an understanding of placement dynamics and the stages of adjustment is critical. Grief and loss are yet other critical areas for practitioners. Finally, professionals must understand typical childhood development and behavior, in order to accurately assess departures from the "normal."
- *Limited community resources.* It takes a village to raise an adopted child with special needs. The local school, church, recreation department, and medical/psychiatric community all need a familiarity with the dynamics of the damaged child as well as the dynamics of child placement. Too often, individuals and systems are judgmental and make assumptions that further undermine the placement. The child and the family are often struggling and drowning together. Blaming is not helpful and serves to leave the child and the family even more isolated.
- *Resistance to seeking help until it is too late.* Some families agree to seek appropriate help for their adopted children, only to stall and even refuse to follow through with the commitment. Some families believe that their faith and devotion to religion will provide all the guidance they need. Others avoid treatment because of negative beliefs about and attitudes toward the fields of psychol-

ogy and psychiatry. By the time these families realize the depth of their crisis, it is often too late to salvage the placement.

- *Lack of support and involvement from extended family and friends.* When the child is initially placed with the adoptive family, extended family and friends are thrilled and make offers to be supportive in any way necessary. But as the going gets tough, they may become uncomfortable with the child's behaviors, as well as with the parenting techniques of the adoptive parents. As relatives and friends become less and less available to the child and parents, the feelings of isolation and condemnation increase.

MORE ABOUT RISK FACTORS IN ADOPTION

The risk factor for an adoptive placement increases with the increased age of the child. When children are adopted as older children, they are often told, "This is your forever family." When that "forever family" decides it can longer care for/parent a child, this is one more betrayal of trust that was at best tenuous to begin with.

Many other factors that influence a child's physical and emotional development may be risk factors in adoption. These include the following:

- The genetic heritage
- The *in utero* experience
- The early nurturing
- The nature of previous placements in foster care or orphanages

The importance of genetic heritage cannot be underestimated. There is increasing knowledge of the personality and behavioral traits that are predetermined and passed on through genes. Even children who have been removed immediately after birth from their birth parents often exhibit many behaviors and issues similar to those of the birth parents. In addition, the baby's *in utero* experience may have been nurturing and peaceful, or it may have been malnourished and substance-contaminated. Few birth mothers with heavy substance use or addictions report accurately regarding their usage during pregnancy, thereby leaving the nature of the child's prenatal and perinatal nurturing unknown. Finally, the fact a child has been in foster care or in an orphanage, as opposed to living on the street, does not guarantee that the child has been less damaged. There are many wonderful foster homes and orphanages that care for children until they are adopted; there are also many substandard foster homes and orphanages that neglect and abuse the children in their care. Although assessments are completed on children being considered for adoption, there is no way to guarantee accurate information on the intricate details of an infant or child's life prior to the date of placement.

Parenting an adopted child, especially any child past early infancy, is an exercise in putting together a puzzle with missing pieces—many of them edges.

Only after the child moves in do the family members begin to become familiar with one another. Agencies generally do their best to prepare adoptive parents and children for the beginning of their lives together. However, many factors influence and can confound a placement. Ideally, the placement will be supported by the placing agency. If a trained worker is available to the family in the early stages of the placement, issues can be dealt with as they arise. Parenting support for the new parents is critical to the success of the placement. This support should be provided by an experienced social worker who is seasoned and sensitive. The social worker needs to be a child advocate who also understands how destructive and toxic a damaged child can be to a family system or to a single individual who has chosen to adopt. The personnel of agencies offering training to prospective adoptive parents, completing home studies, placing children, and supporting placements now need to be proficient in trauma theory and attachment theory.

ATTACHMENT, LOSS AND TRAUMA

How Early Neglect and Abuse Can Disrupt Attachment and Behavior

The early infant bonding cycle is critical to the development of basic trust—the foundation of all reciprocal human relationships. An infant who experiences discomfort is unable to differentiate among hunger, pain, soiled diapers, or the desire/need to be held and comforted. It is the appropriate response of the caregiver that teaches the infant to identify the source of the discomfort. If the caregiver does not respond to the infant, or responds with an inappropriate offering, the infant does not learn basic trust or learn what his or her needs are. The lack of response or the inappropriate response leaves the infant in a confused state of discomfort and frustration, often expressed as infantile rage. Other typical responses are depression and withdrawal—often seen when infants learn at a very young age (perhaps as young as 3 months) that no one is going to respond to their cries, so there is no point in crying. Consider that this early experience hard-wires the brain and becomes the template within which all other life experiences are processed. For many children who are later adopted, this is often their early infancy experience, which is then compounded by further trauma and repeated losses. It is no wonder that many of the children being adopted past infancy, both domestic and foreign, present serious attachment/behavioral issues. Their presenting issues are the “normal” results of their unfortunate life lessons.

Children in placement are also frequently moved from one placement to another, or from foster care to their birth families and back and forth. Each time a child moves, it is a loss for that child. There may be little or no attachment to the caregiver, but the loss of the caregiver and of all that is familiar to the child leads to feelings of sadness and disorientation. Before the child can regain equilibrium, he or she is often moved again. There is rarely a chance for healing before the wounds are deepened.

Reactive Attachment Disorder

When a child has been unable to develop basic trust because he or she has experienced neglect, abuse, and/or repeated, unresolved losses, the child is likely to develop reactive attachment disorder of infancy or early childhood (RAD). This diagnosis includes a list of symptoms and behaviors that are challenging for the most experienced, compassionate parents (American Psychiatric Association, 2000; Levy & Orlans, 1998). RAD is one of the most difficult diagnoses to treat, as the treatment must occur on numerous levels simultaneously. The basic trust issue requires reworking, through the creation of a new template of consistent nurturing and unconditional love. The individual child needs intensive therapy to create a sense of self, an identity, and self-worth. The child and the parent both require assistance in developing a bond and attachment. Then there are family, educational, and community issues to be addressed. Traditional therapy is based on a reciprocal, trusting relationship, which these children cannot form. The need for alternative types of therapy is addressed later in this chapter.

Adoptions involving any child past early infancy are likely to involve trauma and attachment issues. Many professionals in the field and many adoptive applicants believe that very young children have no memory of their early life experiences. However, recent trauma research has revealed that the body remembers what the child may not be able to conceptualize and express verbally (van der Kolk, 1987; Rothschild, 2000). These memories and lack of basic trust later become expressed behaviorally.

The Impact of Early Abuse and Neglect on Adoptive Placements

When children are not able to attach, they live in an environment that is ego-dystonic to them. Their energy is dedicated to transforming their adoptive families into what is familiar to them, consciously and unconsciously. These children have an overwhelming need to control their environment. This need can apply to the smallest of tasks (e.g., brushing their teeth), as well as to the largest issue (i.e., establishing who is in charge). They test their parents in very creative and persistent ways, making everything a battle.

In recent decades, the influx of Romanian and Russian orphans into the United States has taught us how damaged a child can be from early childhood neglect and abuse. When children are adopted from such deprived environments, they are often severely damaged at an early age. The behaviors and issues they present are complex and challenging. The same may be true of children from other foreign countries and from severely troubled backgrounds within the United States. The tragedy is that the hard-wiring of these children's brains is already complete. The templates upon which they will experience life are already established. There can be modifications and adjustments to their hard-wiring, but the patterns of functioning are in place. For these young children, love is not enough; adequate parenting will entail long-term, therapeutic, skilled interventions. Their needs often encompass medical, psychological, and educational services. Adoptive parents are rarely prepared for the emotional and financial investment that is required to parent these children.

HOW TO HELP CHILDREN AND FAMILIES THROUGH DISRUPTION AND DISSOLUTION

Everyone who is dealing with adoption disruption or dissolution is hurting. The pain may be expressed as anger and frustration, or as depression and hopelessness. The issue is how best to help the child in crisis, as well as the family in crisis. Often the professionals assisting the child and family also have a difficult time and tend to assign blame for the "failure" of the placement.

Determining What Supports Will Be Helpful

Typically when a child is in crisis, a critical part of the assessment is determining what supports will be helpful to the child through recovery. When a child's adoptive placement is disrupted, the supports available to the child are almost nonexistent. This is a situation where the child loses almost everything familiar to him or her except the agency and/or state child welfare employees. The child is losing not only his or her nurturer and family, but also school, community, church, coaches, Scout leader, physician, dentist, pets, neighbors, extended family, and lifestyle. Even in those cases where children or adolescents have sabotaged their own placements, the loss of that which is known is still significant. A highly recommended resource for any family or professional dealing with disruption or dissolution is *A Parent's Guide to Adoption Disruption and Dissolution* (Laws & Ashe, 2006).

Treating the Traumatized, Unattached Child

There is an ongoing controversy or difference of opinions as to which therapies are effective in treating the unattached child. Traditional play and sandplay therapy have been criticized as being ineffective in treating RAD, because they tend to be nondirective and an unattached child is masterful at avoidance techniques. Talk or relationship therapy is also deemed ineffective, because it relies on a reciprocal relationship with a helping individual, based on trust—two things that an unattached child is incapable of establishing. Attachment therapies, including holding and reparenting/regression, have had some success, as have "theraplay" and filial play therapy. The degree of difficulty in building trust in an unattached child lends to an inclusionary rather than an exclusionary approach to treatment. It is likely to take a combination of methods, skillfully delivered, to treat the child and family. It is not a question of belief in a particular approach; it is an issue of what will be helpful in which cases and when. Therapy for children who are so damaged requires several levels of treatment simultaneously:

1. *Individual therapy to heal the trauma wounds the child brings into placement.* This is best accomplished through individual work with the child, utilizing traditional play therapy, sandplay therapy, expressive therapies, and eye movement desensitization and reprocessing (EMDR).

2. *Conjoint therapy with the primary nurturer to develop trust and facilitate communication.* The goal is to promote trust, bonding, and attachment with the adoptive parent(s). This can be accomplished through the therapies mentioned above, as well as through theraplay and filial play therapy.

3. *Family sessions to incorporate the child into the adoptive family system.* This generally requires family sessions that utilize the methods named above. Traditional family therapy is often not effective for unattached children, because they cannot perform at the level of the other family members. Their lack of awareness of feelings, their inability to communicate verbally (see below), their lack of insight, and their tendency to blame others for their troubles make verbal family therapy frustrating for all participants. Perhaps after levels 1 and 2 above are successful, then traditional family therapy may be effective.

The majority of children with early trauma histories are not able to use verbalizations to express their painful experiences. Many of their memories are preverbal and are carried in the cells of their bodies. Nonverbal methods of expression, such as traditional play therapy, sandplay therapy, and expressive therapies (e.g., art, music, and dance), can access the memories and provide an avenue of release and healing. However, nondirective therapeutic methods may allow children to avoid critical material that they need to address in therapy. Therefore, a combination of directive and nondirective methods is recommended. Sometimes this takes the form of an agreement that a portion of the session will be determined by the therapist, while the remaining portion will be determined by the child. Over the years, I have treated a number of sexually abused children who had not addressed their sexual abuse in previous therapies. Their explanation for the omission was "Nobody ever asked." It is important in such cases for the therapist to be direct, reaching for the suspected emotionally charged material. Any child would prefer to avoid painful, embarrassing, and/or shameful memories.

Despite the best efforts of adoptive parents and supporting professionals, some adoptive placements will not endure. When disruption or dissolution is imminent, both the child and the parent(s) deserve respectful, sensitive treatment. It is a time when emotions are raw, anger and resentment are high, and the unknown is looming over the child and family. The decision to end the placement causes the child to exhibit confused reactions, ranging from relief to anger and hurt. It validates the child's feelings of being disposable, a "throwaway child." Children in placement often fantasize a return to their birth families or to previous foster families. Although they may have been told repeatedly that they will not be returning to these families, the disruption or dissolution reinforces that reality. Whatever the circumstances, the actual decision to terminate the placement comes as an emotional blow to a child, and the uncertainty of what will come next is devastatingly stressful.

At this time of crisis, the adoptive family needs to be as supportive to the child as possible. This can be a difficult task, because the parents are typically at their wits' end and emotionally spent. They are often feeling misunderstood and devalued by their agency, extended family, friends, school, church, and the court system. The only persons who really seem to understand are those individuals who have parented an unattached child themselves. It is a lonely, isolated period in their lives.

One such situation was the case of a social worker who, with her husband, had adopted several older children. One of those children exhibited severely disturbed behavior, necessitating psychiatric hospitalization and residential treatment. When he was eventually returned home, he became unrelentingly physically threatening. The parents feared for their own safety and that of the other children. They made the tortured decision to dissolve the adoption. The state agency and the court system treated them so shabbily that the mother chose to leave the field of social work and attend law school. Her life is now dedicated to helping other adoptive families navigate/fight the very systems that should be supportive and helpful.

Children whose placements end go on to other placements. The end of a placement is not the end of their lives; it is the end of a chapter in their lives. This fact can be verbally stated, and can be supported by lifebook entries and photo albums. The EMDR storytelling technique developed by Joan Lovett, and described in her book *Small Wonders* (Lovett, 1999) is a very effective tool for helping children through trauma and conveying the message of hope. A scrapbook of the period spent with an adoptive family can also be helpful, leaving blank pages at the end for the next "chapter."

Some adoptive parents express interest in maintaining contact with the child even after a placement is terminated. This continuity in relationships can be helpful for the child, but is often frowned upon by agency workers and subsequent caregivers.

ADOPTION DISRUPTION: THE CASE OF MARNEY, AGE 11

This case is a composite case compiled from three preadoptive cases that were disrupted before the adoptions were finalized. This format was chosen to represent the effective treatment strategies, as well as to protect the confidentiality of the children and families.

Family Information

Marney was the eldest of a group of three sisters. They first entered the foster care system at ages 7, 5, and 3 years, as a result of parental neglect. Marney, the 7-year-old, required placement in a therapeutic group home. Her two younger sisters, Meg, 5, and Ann, 3, were placed together in a foster home. The case plan was originally to return the children to the care of their biological parents. They visited with the parents regularly; after each home visit, however, their behaviors were extremely challenging. The younger girls eventually required two additional foster home placements. Regular visits with the biological parents continued until termination of their parental rights became the case plan. This change was made because of the biological parents' inability to comply with the requirements to provide a clean, safe environment for their children, and because of new disclosures made by the children regarding physical and sexual abuse.

The three children had spent their infancy and early years with their biological parents, who were limited both intellectually and emotionally. Their home was filthy and inhabited by numerous pets. The children were often unkempt and hungry. When they were removed from the care of their parents, the neglect was obvious and documented. As the children entered therapy and began to feel safe in their foster homes, they began to disclose physical and sexual abuse. Both their mother and their father had abused all three children. Marney seemed to be the most damaged, having lived with her parents the longest. Meg was next, and Ann, the youngest, seemed to have been the least damaged by the abuse.

The foster mother, Sue, 37, an elementary school teacher, had always wanted a family but had never married. Her decision to adopt a sibling group was intended both to provide her with a family, and to provide a service by keeping a sibling group together. The two younger sisters were placed with Sue when they were 7 and 5. The plan was to place Marney with Sue and her two sisters as soon as she seemed ready for a family experience.

Any one of the three siblings would have presented a challenge to an experienced two-parent family. This placement was especially intense and complex, due to the inexperience of the foster/adoptive mother, as well as the fact that she was a single parent and was outnumbered from the date of placement of Meg and Ann. The younger two children were diagnosed with posttraumatic stress disorder (PTSD) as well as RAD. Their lists of symptoms were long and difficult. But both girls were invested in being a family with Sue at the helm, and they all worked hard to accomplish that goal. Although Marney continued to exhibit behaviors that required skilled care, both Sue and the agency eventually decided that it was time to have her join the family.

However, when Marney joined the family, the situation quickly became a crisis. Like her sisters, Marney was diagnosed with PTSD and RAD, but unlike Meg and Ann, she had no desire to be a member of Sue's family or to accept Sue as her mother. Her fantasy was to return home to her biological family. She forbade her sisters to call Sue "Mom" and insisted they call her Sue. Immediately after being placed in the family, Marney began to exhibit rageful behaviors. Despite medication, her rage attacks lasted for hours and often required physical restraint; during her rages, she verbally and physically struck out at all the family members. Her two younger siblings were further traumatized by Marney's behavior. Marney frequently urinated in the house and on several occasions defecated in her sisters' shoes. She even pooped in the swimming pool, forcing her younger sisters to watch. Her hygiene was poor in other respects as well; she refused to shower or brush her teeth. In addition, Marney stole from her family members, lied about almost everything, assigned blame for even the smallest of deeds, hoarded food, and tried to engage her two younger siblings in sexual behaviors. Marney fought for control over every aspect of her life and competed with Sue for the role of mother-in-charge, as she had been responsible for the care of her two younger siblings when living with the biological parents.

From the time of her placement with Sue, Marney was in weekly therapy with me. The placement of all three girls was supported by therapeutic foster care rates, which at the time of the adoption finalization would become adoption subsidies. In addition to financial support, the placing agency offered supportive services when needed. The agency helped facilitate finding the girls appropriate therapy, psychotropic medication management, extracurricular activities, and remedial education services. Sue's extended family members were primary supports to her family, assisting with child care and providing family gatherings and outings.

For purposes of receiving special services in school, Marney was described as having severe emotional disturbances and a learning disability. Her third-grade teacher was troubled by Marney's habit of talking to her fingers and imitating animals of all sizes. She also chewed her fingernails, refused to keep herself and her workspace clean, had no friends, and was socially isolated. Because her behaviors both at school and at home were so bizarre and dangerous, the treatment team decided that a summer residential therapeutic program was indicated. The staff at the program assessed Marney, Sue, and the family. The recommendation was that Marney *not* be adopted by Sue, who was having a very difficult time making the decision to disrupt the placement. The supervising agency agreed with the recommendation, and Marney was returned home for a short period to be notified of this decision and to have a short period of closure with Sue and her sisters.

Sue was devastated, as she had considered this summer placement as a respite and a way to learn more effective parenting skills. Although the task was daunting, she had hoped to be able to keep the girls together.

Problems to Be Addressed with the Child

- How to tell Marney that she was not going to be adopted by Sue, and that she would be moving on to another placement. Sue cared about Marney, but felt that she could not manage her aggressive acting-out behavior or keep any of them safe. However, the two younger children were staying with and were being adopted by Sue.
- How to explain why the placement was being terminated, without assigning blame.
- How to give Marney a sense of her future without making false promises, and how to reassure her that she would not lose contact with her sisters.
- How to convey to Marney that the adults would work together to make sure she was safe and well cared for.

Session 1

Content of Session	*Rationale/Analysis*
Therapist: Marney, we are meeting today with Sue to explain to you a very big, very difficult decision that Sue has made. You are aware that things have been very difficult at home, right?	
Marney: Yeah.	Reluctantly admits the reality.
T: Would you agree that there has been a lot of tension and fighting between Sue, you, and your sisters?	I am trying to further establish Marney's sense of reality.
M: They won't leave me alone. They all get on my nerves.	As is typical of unattached children, Marney assigns blame to others.
T: I know that they must get on your nerves. But the behaviors that are happening as a result of them getting on your nerves are way out of control.	I am gently trying to open this discussion, all the while dying inside for this child who has already had so many losses and traumas.
M: I get mad. They make me mad!	
T: I realize that we have spent a lot of time trying to fix this situation, but it is beginning to look not fixable. When Sue decided to adopt you and your sisters, she wanted very much to be able to keep you all together. But now, even though she has tried to be a mom to all three of you and you have all tried to be a family, it just isn't working.	I am acknowledging the work we have all done to try to save this placement. Then I gently move on to explain why this disruption is going to occur.
Sue: This is not your fault, Marney. It is just too much for me, a single parent, to do all by myself. I can't continue to restrain you when you get so angry. You are getting too big and strong for me to be able to keep us all safe.	Sue and I have prepared well for this session. She accepts responsibility for not being able to parent Marney.
T: What Sue is explaining is that because you express your feelings so physically, she can't keep you all safe. That's why she is not going to be able to adopt you.	Sue is feeling a great deal of guilt, so I intervene so she can manage her own emotions.
M: What about Meg and Ann? We have to be together!	Marney is not invested in being adopted or in being a part of this family. She does not want her sisters to be parented by Sue when she feels it is her job. She has

	been a parentified child and feels that her sisters belong with her, in her care.
S: They will be staying with me. I still plan to adopt them.	Even if Marney is ambivalent about wanting to be in the family, having to deliver this message is painful to all parties.
M: THAT'S NOT FAIR! You promised me I would be adopted, too.	
T: It isn't fair in many ways, Marney. When Sue, your social worker, and I kept saying, "This is your forever family," we believed it would be. None of us knew it would be so difficult for you all to be a family.	
S: I wanted to be your mom. I wanted to adopt all three of you and keep you all together. (*Crying*) But it is just too much for me. I can't do it. But I still love you and still want you to see your sisters.	Sue is able to verbalize her feelings and explain why she cannot adopt Marney.
M: You never wanted me. You don't love me. You just wanted my sisters.	A very typical response. Marney is feeling displaced and rejected by Sue.
S: I am sorry you feel that way. I wanted very much to be your mom. Letting me be your mom has been very hard for you.	Sue is reassuring, but begins to introduce the reality of their dynamics.
T: Marney, you and I have talked a lot about your mixed feelings. On the one hand, you want to be with your sisters; on the other, you want to be with Grace [her biological mother].	Marney's wish to be with Grace is a long-held one. Often children will sabotage their placements, believing they will be returned to their biological parents.
M: Does she know I'm not being adopted?	
T: No, she hasn't been told yet.	
M: Am I going back to live with her?	
T: No, Marney. Grace wasn't able to take care of you when you were little, and she cannot now. It takes all of her energy to try to take care of herself.	I reinforce reality.
M: Maybe she has changed?	Marney is probably hoping that Grace will come to her rescue.
T: I know that in your heart you want her to be able to take care of you, but your social worker has contact with Grace and knows she just cannot do it. But	I acknowledge her feeling, but again reinforce reality. I need to address her fears and worries about what will happen next.

you have to be worried about who will take care of you, right?	
M: Yeah, where am I going?	
T: Well, your social worker, Sue, and I have been working really hard to find a place you can go to live where they will take very good care of you. We looked for a place close enough for you to be able to visit with Meg and Ann, and to be able to continue in counseling with me. We have found a very nice family with two cats and three dogs. They have kids, but the kids are all grown up. You will be the only child in the home and can get lots of attention.	A child who is about to lose everything familiar needs to be repeatedly reassured that the adults in her life are in control and can keep her safe. Marney loves animals. Many abused, neglected, and unattached children are very attached to animals; the animals have been there to nurture them when humans were not.
M: When do I go?	
T: We are going to go slowly. First you will meet them, then spend a day with them, then stay there overnight. We do not have a move-in date, but we will introduce you to them next week. Your social worker will make the arrangements.	The foster parents have already made a commitment to take Marney. I have met with them to describe her needs. They seem to minimize Marney's issues, and I do fear that this placement may not last, either. I try to be positive in my tone and affect.

After several other sessions preparing her for placement, Marney went on to live in the new foster family, where her behavior continued to escalate. Despite the efforts of a team of professionals, Marney was not able to be maintained in a family. She was hospitalized for an extensive period until placement in a residential program could be arranged. Marney remained there until her 18th birthday, at which time she was released to an extended family member, a relative of her birth mother.

Meg and Ann were adopted by Sue. The day the adoption was finalized, both girls were thrilled to *know* Sue would always be their mother, but saddened that Marney was not able to be a part of their new life together.

SUMMARY COMMENTS ON DISRUPTED/DISSOLVED PLACEMENTS

When a placement is disrupted, a wealth of information about the child's background should be shared with the next caregiver or foster family. Unfortunately, this information may not be provided, or may be provided only in selective disclosures over time. Sometimes the placing worker may not believe that the child is really *that* disturbed, or may believe that the adoptive parents' issues were what led to the disruption of the placement. Or the worker may hope that a fresh start without contamination from the previous placement(s) will increase the probability of success. Whatever the reason, this can be a dangerous perspective, as severely disturbed children are often repeatedly re-placed in unsuspecting, trusting families. When full disclosure occurs, the family members must make a decision as to whether meeting the child's needs is within their ability to parent; this makes further disruptions less likely. The desire to see the child settled in a "forever family" can sometimes cloud clinical/professional judgment. There are some children who simply cannot succeed in a family. Their lack of basic trust, rage, and fear of intimacy make it impossible for them to form attachments with parental figures. These children are more successful in group settings, where it is easier for them to distance themselves emotionally. A common placement error that is made with a difficult child is to assume that being an only child will afford him or her all the necessary attention. This tends to create an intense relationship with the parents that is too stressful for all parties. The child is parented under a microscope where his or her every move, failure, or achievement is amplified. The answer for some of these children is a large family with many siblings, so that the parent–child relationship is less intense.

CONCLUSION

Treatment of adoption disruption and dissolution is intense. Everyone is hurting—the adoptee, the adoptive family, and many of the professionals involved. It is a crisis rife with possibilities for blaming, judging, and dismissing the parties involved. Rescue fantasies and the belief in the "ideal family" can undermine the reality of the situation. When the decision to end the placement is made and the wheels are set in motion, damage control has to be the first priority. When people are desperate, they say and do things they later regret. Whenever possible, adoptive parents' verbalizations should be rehearsed: at the very least, they should follow a general script as to what to say and what to avoid. The child and parents alike need preparation regarding what they will feel and how best to deal with their feelings. Of course, the child/adolescent must be viewed as the primary client. The child stands to lose everything—family, home, community, material goods, lifestyle, extended family, school, friends/peers, and sports teams. The child even loses the familiar sensory stimulation of smells, tastes, sounds, and textures. It is always said that children are resilient, but the inflicting of wound after wound, without allowing any of them to heal, inevitably takes its emotional toll. Supporting the family is also critical, but the reality is that the family members will still have each other—their home, their church, their community, and all that defines their lives together—while the child remains alone.

No one enters adoption with the vision of having to terminate the placement through either disruption or dissolution. In the initial stage of the placement, the child and the parents are thrilled to have found each other. The adoptive family intends to love, nurture, and support the adopted child throughout his or her life. Disruption or dissolution is one of the most tortured, painful decisions a family can make. It hurts the child, the parents, the extended family, and the community members. The healing is slow and sometimes never complete.

Study Questions

1. Discuss the difference between disruption of a placement and dissolution of an adoptive placement. Consider the psychological damage each might cause to the child and family. How can the trauma be minimized?
2. Professionals often have their own strong feelings about and reactions to the failure of a permanent placement. How can a professional best manage his or her own emotions? Would it ever be appropriate or helpful to share those feelings with the child or family?
3. When a child is in crisis and projects his or her inner chaotic world into the playroom or sandtray, how should the therapist respond? Discuss under what circumstances the mess should be left, and under what circumstances the therapist should help the child make order of chaos and pick the mess up.
4. Are there some children who simply cannot live in a family? How should that be determined, and by whom? What alternative living solutions are available or could be developed?
5. Knowing that many international adoptions (e.g., those of children from Romanian and Russian orphanages) are at particularly high risk for special-needs services, disruption, and dissolution, should they be restricted in any way? Should specific conditions be written into the adoption agreement that provides the adoptive families with the same rights as those who adopt domestically? Whose legal and financial responsibility should it be to treat and educate these children when the adoption fails?

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Chapter 9

After a Parent's Death

GROUP, FAMILY, AND INDIVIDUAL THERAPY TO HELP CHILDREN

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THEORETICAL FRAMEWORK

In 1940, British developmental psychologist John Bowlby incensed his psychoanalytic colleagues through propositions that he later developed into his theory of attachment (see Bowlby, 1969, 1973, 1980, 1988). One basic tenet of this theory is that separation anxiety in children results from adverse family experiences, such as real or threatened abandonment or rejection, illness, or death. Bowlby's theories and writings have been adapted to form the foundation of much of current scholarship and practice with children, including the areas of grief and loss.

More recent research on the brain and neuroscience has provided additional insight into Bowlby's pioneering work, though not necessarily different conclusions. For example, child psychiatrist Daniel Siegel's research into how the brain works (see Siegel, 1999) suggests that "from the moment we're born, our most important relationships fire into being the neural circuits of the brain that allow us to understand and empathize with others and feel their feelings" (Wylie, 2004, p. 30).

In 1988 Siegel attended a talk by Mary Main, one of the pioneers in attachment theory, on her work in "coherent narrative." Main's research indicated that the way parents told their stories—how they made sense of their past lives—was the most powerful predictor (85% accuracy) of whether their own children would be securely attached to them. "It wasn't *what* happened to them as children, but *how* they came to make sense of what happened to them that predicted their emotional integration as adults and what kind of parents they'd be" (Wylie, 2004, p. 34). In other words, *making meaning* of one's childhood, regardless of the actual events, corresponded positively with "emotional integration" and better parenting.

Siegel's applications of Bowlby's and Main's underlying principles have opened new vistas in the understanding of how early experiences affect the brain and future feelings and behaviors. Perhaps the most relevant application is Siegel's belief regarding the most important element in the therapeutic relationship (whether therapy or support). This concept came from a young woman he was seeing in therapy who "was suffering from unresolved grief and guilt at the loss of a parent. Eventually, she got better, and when she was ready to leave, Siegel asked her what had been most helpful about her treatment. She thought for a minute and then said, 'When I'm with you, I feel *felt*' " (Wylie, 2004, p. 33). Our role—whether as play therapists or counselors, grief support practitioners or psychologists—is helping the children and families we serve to *make meaning* through *feeling felt*. It's that simple, and that complex.

This chapter discusses the principles, goals, and components of the first peer grief support program in the United States for children, teens, and families who have experienced a death. It provides an overview of how children grieve and how they understand death and loss, both of which are based in part on their developmental age. Examples of how to support them in healthy behaviors are provided, as well as suggestions for working therapeutically with them as they seek to make sense of their losses.

THE DOUGY CENTER MODEL

The Dougy Center's peer support group model arose in 1982 out of the need to provide a safe environment for grieving children and families to come together and share their experiences—to make meaning, and to feel felt. The founder, Beverly Chappell, a former nurse and the wife of a pediatrician, recognized society's inability to provide adequate support for grieving children and families. The Dougy Center's model is based on four principles about grief, which inform the structure of our program and guide our interactions and responses to the children, teens, young adults, and adults who access our services.

Four Principles about Grief

The first principle of the program is that grief is a natural reaction to death. Grief is often labeled as a set of behaviors and experiences that need to be alleviated or changed in some way. We believe that grief is the expected and healthy response to a death. Rather than "treating" or "fixing" children and their families, our peer support groups help participants learn to integrate the loss into their lives. The participants in our program talk about—and play out—the death's impact on them emotionally, behaviorally, physically, cognitively, and spiritually. These discussions work to normalize their reactions and decrease the fear that people in grief are crazy, sick, or damaged in some way.

Unfortunately, sometimes responses are labeled with terms like "pathological grief," as if these reactions are somehow "crazy" and in need of curing. The center's participant children have experienced tragic deaths of parents, siblings, and friends from every imaginable accident and disease, as well as horrific murders and suicide deaths, some of which they have actually witnessed. Rather than labeling their responses as "acting-out" behavior, or as "pathological," we choose to view all behaviors as attempts to cope. Some of these attempts may be harmful to a child or to others, and may require professional attention or perhaps therapeutic support. But an "acting-out" response to, for example, watching your father shoot and kill your mother and then himself is not *pathological*. Rather, it is *normal* for a child in such circumstances to have nightmares, and perhaps to "act out" the pain inside by becoming aggressive toward others. In other words, neither the grief nor the response is pathological.

Our second principle is that each person has the natural capacity to heal. Because The Dougy Center provides a safe and confidential environment for children and their families to come together with others dealing with grief, participants can learn from and offer mutual support to others based on their personal experiences. Children are able to hear how others their same age have dealt with school, family members, and friends after a death. From these exchanges, children and adults are able to gather new ideas that fit with their way of living with the death. This is not to suggest that "time heals all wounds," or that professional intervention is never warranted. Rather, we propose that with supportive healing conditions, everyone has the capacity to heal. These healing conditions include opportunities for expression, as well as the innate need to be understood. (The need for understanding is poignantly captured in Figure 9.1.)

In addition to telling and hearing stories, many children benefit from alternative means for expression. To address this, we provide opportunities in the areas of art, dramatic play, and "big-energy" work. While some children are eager to tell their stories and share verbally, others prefer more physical avenues to process their reactions, or simply are too young to have a verbal vocabulary to

FIGURE 9.1. Free-time drawing done by a 7-year-old girl whose dad died by suicide.

express their feelings. Our belief that everyone has the capacity to discover what he or she needs in times of grief guides our nondirective model, which allows children to choose what they need to do at The Dougy Center. The staff members and volunteer group facilitators are trained to reflect what children do and say, rather than to interpret or lead conversations and play. In this way, children are encouraged to find their own way both at The Dougy Center and in their grief process. Selecting their activities and means of expression aids them in restoring the lost sense of control that accompanies a death they could not prevent.

Our third principle is that the duration and intensity of grief are unique to each individual. We believe strongly that there is no one way to grieve, and that even within families people will travel different paths after someone dies. How each person experiences grief will depend on a number of factors, but these factors cannot solely predict his or her reactions. Age, relationship, existing challenges and strengths, the nature of the death, and the grieving person's framework for creating meaning all mold how grief looks and feels. Our nondirective peer support groups work to acknowledge that each person is different and that there are many ways to respond during times of grief. Within a family, one child may want to keep pictures of his dad who died around the house, while his sister wants them taken down and stored out of sight. In another, the surviving parent may want to talk with his children about their mother, while the children prefer to talk to their friends. The peer support group helps families understand that each member's wishes are valid and that there are ways to mutually respect those differing needs. A child may learn from another participant that he can ask to hang pictures of his dad in his room, so that his sister doesn't have to be around them all of the time. A dad can talk about his wife with his peer support group and learn that his children are not the only ones available to listen.

Within this third principle is the understanding that grief is not something children and their families have to "get over." Grief is a mutable experience that changes over time and exists on a spectrum from very intense to very manageable. We believe that grief is not a linear course that moves from stage to stage, but rather something experienced in waves. As children grow and reach various developmental milestones, they may reexperience their grief, since they are equipped with new cognitive capacities and comprehension to process the death and the impact it continues to have in their lives. This conceptualization of grief as ongoing drives our commitment to offering open-ended peer support groups as opposed to time-limited sessions. Children choose when they want to join a group and when they are ready to leave our program.

Our fourth principle—that caring and acceptance assist in the healing process—is based on the belief that our society does not accept death and does a poor job of equipping people to comfort bereaved individuals. Parentally bereaved children are often told to "move on" and "get over" their grief in a limited period of time. In the school setting, students may encounter pressure to concentrate and complete assignments, with no acknowledgment of the ways in which grief can limit a child's ability to concentrate. The structure and routine at home are often disrupted after a death, which in turn affects a child's capacity to focus on and to complete homework. In the work setting, surviving parents may lack support not only for their grief, but also for the additional responsibilities that come with being a single parent.

Our peer support groups provide children and their families with an environment in which to share their challenges while grieving. Many of these challenges come from outside forces, but some of them are also internal. Children may feel responsible about taking on additional household tasks, while older children may be expected to babysit younger siblings (or expect it themselves). In the group, children can talk about these changing roles and responsibilities. They can also utilize our creative expression rooms to play or act out these shifts in their lives. According to the literature, "attachment relationships that offer children experiences that provide them with emotional connection and safety, both in the home and in the community, may be able to confer resilience and more flexible modes of adaptation in the face of adversity" (Siegel, 1999, p. 59). As a result, our staff members and volunteer facilitators rely on the essential skill of reflective communication, in order to create a warm and caring atmosphere that makes children feel safe enough to express their feelings.

In the adult groups, which run concurrently with the children's groups, caregivers talk about the challenges and opportunities they face in parenting their grieving children. The ongoing nature of our program means that the groups have a wide range in terms of length of time since the death. When an adult or child comes to a group for the first time, he or she may encounter people who are 1 month, 6 months, or 4+ years from the time of the death. The established members are able to offer both hope and understanding to the more recent members. In their separate groups, children and caregivers are invited to tell stories about the person who died. Sometimes these stories relate to the death itself and how the griever found out or what he or she saw and felt at the time. Other stories focus on memories that the participants have about their lives with the person who died. People dealing with grief often use stories to help make sense of and connect the pieces of their lives before and after the death. Being able to share stories helps participants to connect through the common experience of piecing their histories together (Siegel, 1999).

The previous paragraphs outline the four principles that undergird the peer support group model used at The Dougy Center. Our program strives to create a supportive environment where bereaved children and their families can find social support and healthy outlets for their feelings and reactions associated with grief. These principles are informed by what we know from the literature, as well as our experiences of how children grieve and how their developmental stage influences the process.

Goals

Some of the goals of our work, applicable whether we are seeing grieving children individually or in groups, include the following:

1. To help restore the children's damaged sense of control.
2. To normalize their experience: "I'm not alone. I'm not crazy. There are other kids like me who feel what I do. I'm going to be OK."
3. To provide social support and let the children know that others care.
4. To let them know that "my feelings matter!"
5. To provide outlets for their feelings, whether they can verbally articulate them or not.
6. To help them keep a connection with the deceased—to re-member.
7. To help them see their own progress, and give them the opportunity to help others.

Group Meetings

Our ongoing groups meet every other week throughout the year, for an hour and a half, with a brief summer break. The conditions for participation include adherence to a small number of safety rules. We've successfully integrated children we were initially told could not "function" in a group setting. What we've found is that through permitting these children to guide their own play and their own activities within the safety guidelines, even children with histories of "acting out" (again, we view these as *coping behaviors*) can successfully participate in the groups.

Individual Therapy

Although The Dougy Center's model is a group model, which we believe assists in normalization and socialization, the principles, methods, and activities can also be integrated into individual therapy. We recognize that some children, teens, and adults do not wish to be in a group setting for various reasons, including shyness, wanting more individualized attention, or being overwhelmed by other people's stories. Additionally, individual or family therapy may be indicated, either instead of or in conjunction with support groups, when a family is struggling with additional major issues (e.g., substance abuse or domestic violence) or when behavioral issues interfere with a child's ability to maintain safety for self and others.

Family Therapy

Because death has an impact on everyone in a family, we believe that family involvement in support or therapy is more helpful than treatment of a specified "problem" individual. The work of such researchers as Irwin Sandler and Tim Ayers (Lutzke, Ayers, Sandler, & Barr, 1997), Phyllis Silverman (2000), Nancy Boyd Webb (2002), and J. William Worden (1996) unequivocally points out the influence of the health of the surviving parent on bereaved children. Coping with the death of a spouse and single parenthood under the strains of bereavement, along with additional changes in income, self-image, and a host of other changes following the death, may strain even the best parent's energy and understanding. Children are deeply affected by how the adults around them cope in times of tragedy, and therefore including the family in therapy or support is paramount. As Silverman (2000, p. 68), one of the coprincipal researchers in a longitudinal study of parentally bereaved children states,

> A good deal of research has been and is being conducted to try to identify factors that would place bereaved children and adolescents at risk of developing emotional problems. This approach stems directly from the model of grieving that focuses on death as a cause of pathology. Yet a direct cause-and-effect relationship cannot be found. A serious illness or death in the family does not, by itself, lead to emotional problems in those affected by the events. Inevitably the research turns to the larger social context to explain the pathologies that do develop.

THE NATURE OF CHILDREN'S GRIEF AND UNDERSTANDING OF DEATH

The following sections provide an overview of the common elements involved in children's grief and understanding of death. In a later section, we describe more specifically how our program works to respond to varying developmental needs.

Young Children Are Concrete in Their Responses

If a person dies who has been consistently present in a baby's life, the infant will have a sense of someone missing. The infant grieves because the consistent, stable environment is in disarray. A young child often does not initially respond to hearing that someone has "died," because the child does not understand the words used by the adults. Many adults are concerned when a child has no reaction or visible grief. It is important to remember that a young child's perception is oriented in the five basic senses. It is concrete, short-ranged, and based on what is being felt in the moment.

Young children do not comprehend the abstract concept of death, but they understand and can feel "gone-ness" (Webb, 2002). Because they have difficulty thinking in abstract concepts and words, words such as "dying" or "died" need to be explained and described concretely. For example, an adult may say, "Daddy's heart stopped working, so his whole body stopped working. He died. When you die, you can't breathe or sleep or eat or poop or laugh, or anything."

It is important to give simple and honest descriptions and explanations. Children who hear that "Mommy's in heaven" may respond, "I know! When's she coming back?" One mother, wishing to help her young daughter understand that her daddy was dead, took her to the cemetery with a dead bird they found in their yard, dug a small hole, and buried it, trying to explain death and cemeteries. The little girl ran and twirled through the gravesites, coming back to announce to her mother, "Look at all the dead birds!" She never made the connection among the dead bird, the cemetery, and her dead father!

Abstract Thinking Gradually Develops

As children mature, their "death data bank" fills, and they begin to grasp the abstract concepts associated with the death they've experienced. They begin to understand that the person will never come back because he or she is "dead," and the word begins to take on new meanings.

Children Generalize from the Specific to the General

If someone died in a hospital, children may think that hospitals are for dying. If someone died in their sleep, children may be afraid to go to sleep. If one person died, "someone [or everyone] else will die," or "I will die." They will learn to accommodate new truths on their own if they are allowed to express themselves.

Children Are Repetitive in Their Grief

Children learn by repetition and by repeatedly asking questions. The answers often do not resolve their searching; the searching itself is part of their grief play. Their questions are indicative of their thoughts and feelings of confusion and uncertainty. Parents should be instructed to listen and support their children's searching by answering patiently and repetitively. They may have to tell the story over and over again as the children learn gradually and grasp the truth.

Children Are Physical in Their Grief

French philosopher Michel de Montaigne (1533–1592) observed that "it should be noted that children at play are not playing about; their games should be seen as their most serious-minded activity."

Young children respond emphatically to their feelings, emotions, and thoughts. What they do with their bodies reveals their feelings, emotions, and thoughts. Grieving is a physical experience for all ages, and most especially for younger children. The older the children are, the more capable they are of expressing themselves in words; yet activity may continue to be a significant way of communicating feelings, emotions, and thoughts. Movement and active play yield communication. Their movements and play speak their language of grieving as much as does their verbal language. Reflecting their words and their play both verbally and physically is a way of understanding and supporting their communication. Thus children will feel that they are being heard and respected, and they may continue to communicate with the adults who are doing the reflecting.

Children Grieve Cyclically

Children's grief work moves in cycles throughout their childhoods—indeed, throughout their lives. Each time they reach a new developmental level, they reintegrate the important events of their lives, using their newly acquired processes and skills. An infant girl whose mother dies will become absorbed in the death again when her language skills develop and she is able to use words for the expression of her feelings and thoughts. She may experience the grief again as an adolescent, using her newly acquired cognitive skills of abstract thinking. The cyclical nature of grieving can be stimulated by acknowledged or unacknowledged calendar events, such as the child's or the deceased person's birthdays and special family events. Children seem to do best when adults remind them of these event dates and suggest options for how to acknowledge them.

Children Need Choices

Death is a disruption in children's lives that is quite frightening. Their lives will probably seem undependable, unstable, confusing, and out of control. These topsy-turvy feelings can be alleviated if the children have some say in what they do or don't do to memorialize the person who died, and to express their feelings and thoughts about the deceased person, the death, and the circumstances that follow.

- Whenever possible, children should be offered informed choices about going to the hospital, viewing the body, attending the funeral, participating in services, and taking part in other options that may be available.
- Children often appreciate being offered pictures and possessions of the deceased person as a way of supporting their grieving process. They should be allowed to choose the clothing, pictures, or other memorabilia they want, and to decide what to do with them.
- A grieving child may assume qualities of the dead person as a way of keeping a sense of that person alive. Mannerisms, preferences, or symptoms of the deceased person may appear.

Children Grieve as Part of a Family

When a family member dies, it will affect the way the family functions as a whole. All the relationships within the family may shift, adjusting to the change in the family's structure. Children may mourn not only the person who died, but also the loss of the environment and structure that existed in the family before the death. Children may have strong feelings and thoughts about the changed behaviors, attitudes, and roles of the family members.

It is helpful if each family member is encouraged to grieve in his or her own way, with support for individual differences. Children seem to do better when they are granted permission to experience and to share other family members' mourning. It is important not to shield children from emotions or thoughts. Offering them the option to stay or leave any gathering will facilitate their sense of inclusion and empowerment, and will help them accept their own feelings and thoughts related to the loss.

Children Experience a Range of Emotions and Feelings

Children's feelings are avenues for them to learn how grief and loss affect them on emotional, physical, cognitive, and spiritual levels. Through this attentiveness to and acceptance of a wide range of feelings and emotions (see Figure 9.2) comes their own understanding about the circumstances of the death, the nature of the relationship lost, and the realities of life without the deceased person. They gradually become acquainted with their own unique grieving and mourning process.

Fear and Anxiety

Two of the most common feelings after a loss for a child are fear and anxiety: fear about past events, and anxiety about the future. They wonder, "What happened? Who will die next? How will we live without the dead person? Will I ever feel better? Will my other parent die? Who will take care of me? Where will I go if I die? Why did it happen to me? Will I die?"

Children of all ages go through their fearful feelings until they come to their own understanding. This may be strenuous for both parents and children, since

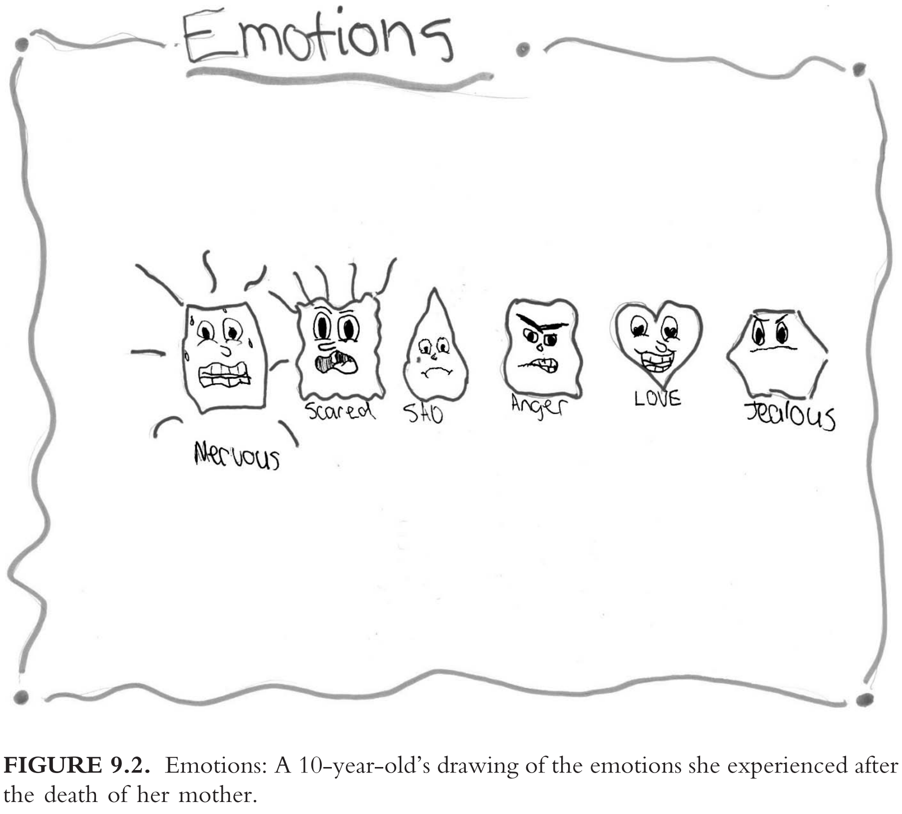

FIGURE 9.2. Emotions: A 10-year-old's drawing of the emotions she experienced after the death of her mother.

this process may include nightmares, physical symptoms, and/or regressions. If children receive attention and nurturing during this fearful time, they will recover a sense of the basic dependability of life and their personal resiliency. Listening to and validating their difficult feelings and emotions will assist them in their grief journey.

Fear can be manifested differently in different children. Some children act younger or regress; they want the reassurance, care, and attention that they received when they were younger. Other children become overachievers in an attempt to contradict their own feelings of helplessness. They may do everything "right," even to the extent of parenting a parent. Some children exhibit exaggerated displays of power to counteract their fears, and this may take the form of superhero manifestations or may surface as disruptive behavior, explosive anger, and/or belligerence. Some children may withdraw, becoming very quiet, almost frozen in fear.

Allison, who was 7 when her mother died suddenly in a car crash, had difficulty going back to her second-grade classroom. Each morning she would struggle with getting dressed and eating breakfast as ways to delay leaving for school. Eventually, her teacher asked Allison what was the scariest part about being at school, to which Allison replied, "I'm scared my dad will die in his car too. If I stay home, he has to stay home too." Working together, the teacher, Allison, and Allison's father devised a plan: Allison could call her father on his cell phone three times a day to check in. Over the course of the next few months, Allison decreased the number of times she called her father per day, until one day she forgot to call him at all.

Guilt and Regret

Guilt or regret may be based on different thoughts related to the death. Guilt may stem from an intentional act that caused or was related to the death. For example, 9-year-old Rian started a fire in which his baby brother died. Guilt may also originate in a false belief that something the child did or failed to do somehow caused the death. This is commonly heard from children who have experienced a suicide death. For instance, 6-year-old Kaitlyn shared this with her group: "If only I had stayed home that night instead of going to my cousin's house, I could have stopped my dad from hanging himself." Regret for actions or failure to act may repeatedly haunt the child's thinking. When adults choose to withhold information about the death from a child, the child may start to think that he or she must have contributed in some way to the death. That is, the child may attempt to make sense out of what is happening by filling in the gaps with his or her own imagined explanations, often with a sense of personal responsibility for what has taken place.

Anger and Frustration

There are different kinds of anger expressed in grieving. There may be unresolved issues between a child and the person who died, which can result in anger in the child. Or a child may feel anger as a protest against the fact of the death and the lack of dependability of life. Anger can also be an antidote to fear, manifesting in an outward display of personal power. A child may communicate through anger that "I am strong enough to control life with my force." A child may become rebellious or resistant to counteract the vulnerability of other feelings and emotions.

Sorrow and Sadness

When a child feels sorrow and sadness, he or she may be ready to accept the truth of the death without protest. Sorrow can be an expression of a child's emotions and feelings of vulnerability about continuing to live without the security of the person who died. The child may be saddened by the loss of security and certainty, as well as the loss of the deceased person.

This exchange between a group facilitator and 8-year-old Zach, whose mother died of cancer, demonstrates how children of this age sometimes verbally share their sadness:

Content of Session	*Rationale/Analysis*
ZACH: When the person died, I . . . I was very, very sad when my mom died.	
FACILITATOR: Sad was the first thing you were when your mom died . . .	
Z: Yeah, *very*, very sad.	Zach lets the facilitator know that she missed the importance of how he was "very, very sad." Reflection is a nonintrusive communication skill that allows children to correct an adult's understanding.
F: Very, very sad . . . what does it look like when you're sad?	Facilitator uses a question to encourage Zach to share more expansively about how sadness affects him.
Z: I cry when I'm sad . . .	
F: You cry when you're sad—I wonder what "sad" looks like for other people sometimes.	Facilitator wonders about Zach's ability to recognize the feelings of others.
Z: Um, some people get really upset and hit things or yell.	
F: Huh, so for you "sad" means crying, but sometimes other people show their sadness by doing things that could look like anger.	Facilitator uses summarizing reflection to show how people express their grief in unique and individual ways.

Children May Exhibit Behavior Changes as Defenses

Children have natural means of protecting themselves from physical and psychological pain. These are often called "defenses." Defenses are often shown in particular behaviors or forms of energy that allow children to cope in their worlds (home, school, sports, neighborhood) during a difficult time. Our job as adults is to honor and respect such defenses, as long as they are not causing harm to the children or others.

DEVELOPMENTAL CONSIDERATIONS

Groups Based on Ages and Experiences

The literature acknowledges that children are influenced by their developmental age, as well as by previous experiences and how they make sense of what has happened. "The meaning that children make may seem strange to adults, if we do not consider that it reflects their age, stage of development, and experience in life" (Silverman, 2000, p. 41). Based on this, the children's groups in our program are divided by age and in some cases by type of death. Our "littles" groups are for children between the ages of 3 and 5. The "littles" are divided by those who have experienced the death of a sibling and those who are dealing with a parent's or other primary caregiver's death.

The next age range is children from 6 to 12 years. This category includes the bulk of the children who attend groups. Within this age range, there are groups specifically for children who have experienced a death due to chronic illness, sudden death (e.g., plane crash, car crash, heart attack), suicide, and violent death. We also offer "middlers" groups for those ages 11–14, teen groups for those ages 13–18, and young adult groups for those ages 19–30. During each of our children's, teen, and young adult groups, there are concurrent peer support groups for the adults and caregivers.

Age-Based Responding

Ages 2–3

Children ages 2–3 are egocentric and believe that the world centers around them. At this point, they lack the cognitive ability to fully grasp the abstract idea of death and related concepts. These children tend to express themselves through behavior and play. As they grapple with the idea of death, they often see it as a reversible condition. It's common to hear children in the "littles" groups ask, "Did you know that my dad died? When will he come home?" For these children, physical items, smells, and sounds associated with the person who died may indicate to them that the person is still alive and can come back. As noted earlier, because children this young are very concrete in their thinking, it's important to explain the death to them in a clear and honest way. It's helpful to talk about the person dying because his or her body stopped working: "Daddy's heart stopped beating, so that means he can't breathe, eat, or sleep any more like you and I can. When someone dies because their body stops working, it means that we won't see him any more. We can't hug or kiss him or play with him." In the opening circle of one of The Dougy Center's "littles" groups, 3-year-old Ebony cried softly, murmuring, "I want my daddy to come back," over and over. Four-year-old Jason, sitting across from her in the group, quietly walked over, knelt down, and said gently, "Dead people don't come back." Children will need these explanations to be repeated often as the reality of the person's continued absence sinks in.

The common grief responses for this age range include general anxiety, irregular sleep, crying, clinginess, and irritability. Children this age are often willing to share their story of who died. Seemingly out of nowhere, they may tell strangers, "My mommy died," and then ask, "Did your mommy die?" They have not yet been socialized to see that death is normally a topic that people don't talk about in public. A death often upsets the structure that children are used to having, so it's important for the adults in their lives to recreate some semblance of routine to reestablish a sense of safety and consistency. Children this age need a variety of creative ways to express the energy of grief that they carry in their bodies. Often this takes the forms of physical activity, dramatic play, and artwork (see Figure 9.3).

Three-year-old Toby had the following routine at The Dougy Center after the opening circle, in which each child says his or her name and has the opportunity to share a thought or show something to the group. Toby would go into one of the playrooms and search for a baby doll. He would take the clothes off the doll and ask to stand on a footstool to reach the sink. He would then fill the sink with water, place the baby in the water, and hold her proudly, exclaiming to

FIGURE 9.3. Younger child's drawing of his mother, who died in a car crash.

everyone, "See, she OK!" Toby's infant sister had accidentally drowned when his mother left to answer a phone call. Saving the baby was one way he "played out" what he'd seen, and his desire to have saved his baby sister. Often after his play Toby would find a place to hide the baby doll, so that it would be in the same place when he returned for his next group. Toby's water play inspired us to build a child-level sink for water play, similar to our child-level sandtray for sandplay.

Sandplay is popular with young children, and we have found over the years that their play is very serious to them. Most often they shun the "fun" Disney characters, selecting "scary" dinosaurs and playing out scenes of rescue. Scenes of people in graveyards, with buried tiny wood coffins and grave markers, often conclude with a child's "saving" everyone. These attempts to change the outcome of the death and loss they've experienced are one way they try to reclaim a sense of control.

Ages 4–7

By the age of 4, children begin to gain a sense of autonomy and start to explore the world outside of them. Their language skills improve, along with their cognitive capacity for wishing and fantasy thinking. They begin to link cause and effect, and this has an impact on how they conceptualize the death. Children at the center often talk about feeling somehow responsible for the death: "I told my sister I hated her, so that's why she died," or "I wore red on the day my dad died, so I'm never wearing red again. Red makes people die." In this age range, children may still ask repetitive questions as they try to make sense of the death, but their questions become more complex. They may ask for more details about how the person died, and may want to know why this happened and who else it might happen to.

Some adults worry that children this age aren't grieving, because they don't always exhibit the signs associated with adult grief, such as crying or a need to talk about the person who died. Many elementary-school-age children grieve in cycles. There can be short periods of strong reactions, mixed with asking if they can go play or acting as if nothing happened. Nightmares, as well as changes in sleeping patterns and eating habits, are common reactions in this age bracket. Some children may lose their appetites, while others are hungry all the time. Many children talk about having difficulty falling and/or staying asleep. It's common for children of this age to be afraid to sleep by themselves for weeks and even months after a person dies.

As with children who are younger, caregivers need to provide children in this age range with clear, concise explanations of the death, worded in a way that fits their cognitive level. Adults should be prepared to answer questions about the how, what, and why of the death over and over again. Children this age need opportunities to talk about the person and to ask questions as much as they need the option *not* to talk or share verbally. Routine and consistency, as well as limit setting (with flexibility), continue to be important.

One boy, Jeremy, age 4, attended The Dougy Center after the death of his mother from cancer. After the initial opening circle, he would routinely go to a playroom and set up trains, often playing with the train set for 30 or 40 minutes. On the surface, no connection could be made between this play and his mother's death. After several months in the group, during a sharing time, the children were asked to tell the others about a happy memory. Jeremy, who usually chose not to talk in the group, proudly announced that "every day on my way to preschool, my mommy drived me there. And we had to stop for the train. We loved to watch the train go by. I miss my mommy."

Here is an example of how reflective communication evolved after another 4-year-old boy, Jackson, saw a dead mouse outside on the lawn:

JACKSON: Look at that mouse!

FACILITATOR: Oh, I see that mouse.

J: He's not moving.

F: Yes, it doesn't look like he's moving.

J: Maybe he's dead . . .

F: Maybe.

J: (*Walks over to the mouse; facilitator follows.*) Yep, he's dead.

F: Yep, he is dead. He's not moving. [Facilitator reinforces, through the child's words, one part of what "dead" means—"not moving."]

J: (*Looks at facilitator*) How did he die?

F: I don't know. I didn't see him die. [Facilitator resists making something up or discussing the possible ways the mouse may have died.]

J: (*Staring at mouse*) Maybe he ate a cat!

F: Maybe! [Facilitator resists informing him that mice don't eat cats!]

J: Or maybe he burned in a fire. [Jackson recently had a fire in his neighborhood where someone died. Again, facilitator resists informing him that it's not likely the mouse died in a fire, since he isn't burned. This is allowing the child's processing to evolve, and accepting his level of understanding.]

F: Maybe.

J: (*After a several-minute quiet period where he simply stares at the mouse*) What do we do now?

F: Well, since he's dead and he can't move any more, maybe we should do something with his body to respect him, and to protect him from anyone stepping on him or eating him.

J: What could we do?

F: Well, when people die, sometimes they are placed in a box called a "casket" and buried in the ground, and sometimes they go to a place where they get "cremated," or their body is burned and they are placed in a container for the people who loved them to keep.

J: (*Quietly taking in this information*) I think we should bury him.

F: OK, let's do that. Do you want to help?

J: (*Enthusiastically*) Yes! What can I do?

F: I'm going to get a shovel, and we'll dig a hole and place him in it.

J: OK.

F: (*Gets a shovel.*) Do you want to dig the hole?

J: I'll help.

F: (*Starts the hole and offers the shovel to him.*) Do you want to help?

J: Yes. (*Digs some of the hole and hands the shovel back.*)

F: Now we're going to place this dead mouse in the hole, so that nothing else can happen to him. Even though he's dead, and can't move or eat or cry or poop, we still want to show that his life mattered.

J: Now what do we do?

F: We're going to put him in the hole we dug.

J: OK. You do that.

F: (*Places the mouse in the hole.*)

J: (*Starts sobbing and cries for several minutes without saying anything.*) [Facilitator resists the temptation to "comfort" him, allowing him to have his tears, and also not interpreting his tears.] That . . . mouse's . . . (*more tears*) . . . that mouse's . . . (*more tears*) . . . family is going to *miss* him! (*sobs*).

F: Yes, that mouse's family *is* going to miss him. (*Facilitator nods and makes eye contact with sobbing Jackson. Both stand looking at the mouse in the hole, while Jackson continues to sob.*)

J: They're really going to . . . miss him!

F: They *are* going to miss him! (*Allows as much time as Jackson needs to take this in.*) So now we're going to put the dirt we dug out over the hole, so his body can't be touched by anyone else.

J: OK. (*They take turns placing the dirt in the hole. He continues to shed tears. Then the tears suddenly stop.*) Let's go play! [Facilitator recognizes that this experience will be one of many future "teachable moments," and resists explaining any more than Jackson asks or indicates.]

Ages 7 to 11

The increased intellectual capacity of children in the 7–11 age range means that they are better able to understand the abstract concept of death. At this period, these children are beginning to establish strong connections with their peer groups and to life outside of their homes. These children still want to view death as reversible, but the finality and permanence of the absence of the person who died are beginning to resonate for them. Once they are able to conceive of death as permanent, they may begin to grapple with abstract questions not only about how the death affects them in the present, but how it will continue to reverberate in future years.

Adults may be surprised by how concerned children this age are with details related to the death and the body. They often ask for and tell stories about the more "gory" elements of death. As younger children often do, children in this age range can also construct lines of thinking that make them responsible for the death. They may think, "If only I had done my homework and cleaned up like my mom wanted, she would have lived," or "I told my friends I wished my dad was dead because he grounded me, and he died that same day." This sense of responsibility can lead to feelings of guilt or regret for what children wished they had done or said differently. Children this age may experience a wide range of emotional responses, including sadness, rage, despair, relief, and fear.

These children often manifest somatic symptoms, such as stomachaches, headaches, general fatigue, and an inability to focus. Sometimes these symptoms mirror those that the deceased person experienced. For example, a girl whose mom died from a brain tumor may develop severe headaches as she attempts to understand the way her mother died. Some children attempt to take on the role of the person who died by caring for the surviving parent, doing extra household chores, or worrying about the family's financial situation. Other fears may arise concerning the potential for other people to die or

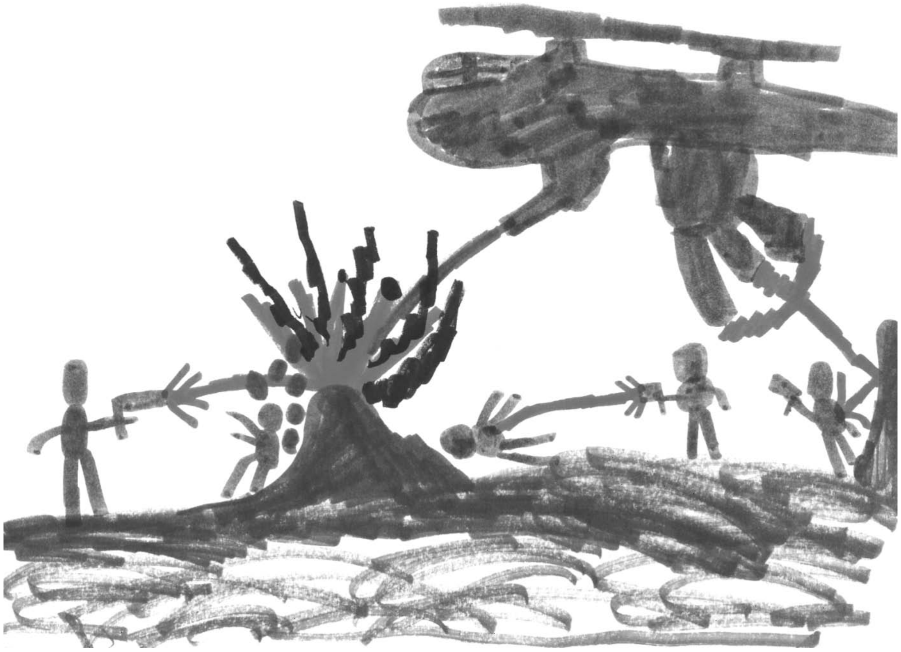

FIGURE 9.4. A 10-year-old boy's drawing of a war scene during free time.

the children's own mortality (see Figure 9.4). Many children talk about having dreams about the person who died, or nightmares about something bad happening to them or their families.

For this age, it's important to provide a wide variety of opportunities for expression. Verbal children will need to talk about the person who died and share memories of their time together. Other children utilize big-energy play such as soccer, running, or throwing pillows to process the more physical elements of their grief responses.

All children this age need to have choices. Choices help them to recreate a sense of power and agency in their own lives. They didn't have a choice about the person dying, but the adults in their lives can provide options in their grief. These choices can be as simple as picking out what shirt to wear that day, or as complex as how they would like to say goodbye to the person who died at the funeral or memorial service. In playing with a 10-year-old girl, Jennifer, whose mother died in a car accident, a facilitator went into the "dress-up" room and waited for directions from the girl. "I'm the doctor," she announced, "and you're the patient." "What's wrong with me, Doctor?" asked the facilitator. "Well, first of all," Jennifer announced seriously, "you have a broken leg." The facilitator grabbed her right leg and started to moan, "Oh, my leg, my leg," to which Jennifer immediately responded, "Not *that* leg!" This illustrates the need children have for regaining a sense of control over their surroundings, especially after their lives have changed so dramatically following a death. It also illustrates the importance of following the child's lead.

Here is another example—a facilitator's interaction with 8-year-old Hayden, whose mother died when he was 5 from a variety of medical complications. This example illustrates the use of reflective communication and curious questions to assist Hayden with sharing memories about his mother, as well as the feelings associated with those memories. The facilitator and Hayden are playing a game where each person in turn selects a piece of colored candy, and then reads a card that corresponds to the color of the candy. The card Hayden has just picked reads: "I wish that . . . "

Content of Session	*Rationale/Analysis*
HAYDEN: I wish that. . . . I wish that my mom never ate too much, because that's how she died.	
FACILITATOR: Oh, so your mom died because she ate too much.	Pure reflection using Hayden's exact words.
H: Yes, she got sick and too big, and then went to the hospital, and that's where she died.	
F: You're thinking that if she hadn't eaten so much and got too big that she wouldn't have had to go to the hospital, and then she wouldn't have died.	Facilitator acknowledges and gives voice to Hayden's assessment of what happened, without questioning it.

H: Yes, your turn.	
F: (*Answers a question.*)	Facilitator participates as a peer griever by answering a question about his own story of loss.
H: (*Takes a new card.*) "Tell us what the person was like when they were angry. . . . " When my mom was angry, she would yell at me a lot.	
F: Your mom yelled when she got angry . . . what was that like?	Reflecting Hayden's words and asking a curious question. Facilitator purposely doesn't ask, "How did it make you feel?", as that question sometimes shuts down the conversation with a child.
H: Yeah, she would yell when I did something wrong, and it was like well I would feel, ummm, frustrated.	
F: Frustrated . . .	Hayden offers up a feeling on his own, and facilitator reflects that to invite him to share more.
H: I wanted her to not yell at me that much.	
F: You wished she would do something else when she was upset at you for doing something wrong . . .	
H: Yes.	
F: (*Answers another question.*)	Facilitator moves on to another question as a way of following Hayden's lead—his one-word answer indicates that he is done with this question.
H: I think I'll pick a card from the "Tell us" cards . . . "Describe the person who died." Umm . . . hmmm.	
F: Do you know what the word "describe" means?	Facilitator reads Hayden's body language and correctly guesses he's hesitating because he doesn't understand the question.
H: I'm not sure; can you help me?	
F: Sure. "Describe the person" means tell us what your mom was like as a person—what she looked like, what she liked to do, what she didn't like . . .	
H: Oh, well, my mom liked to watch a lot of TV. She would stay in bed and watch TV until really late . . . so that that time I was too afraid to be in my bed alone.	This question gives Hayden a chance to have a remembering conversation about his mother.
F: Oh, I see, you used to be scared to be in bed by yourself, so you'd stay up with your mom . . .	
H: Yeah, that's why my mom and dad make sure I go to bed on time.	

F: When you say "my mom and dad," do you mean the people you live with now?	Facilitator uses a clarifying question to make sure he understands what Hayden is trying to describe.
H: Yeah . . . my mom and dad and older sister.	
F: Oh, that's right, Cassie—who's 12, right?	
H: Yeah . . .	
F: You know Hayden, I'm wondering: Besides your bedtime, what else is different about living with your mom who died versus living with your mom and dad now?	Facilitator invites Hayden to express how else his life has changed after his mother's death.
H: Well, my mom and dad don't yell at me like my mom did.	
F: Your mom and dad now don't yell at you, and that's a lot different than when your mom was alive. I wonder, are there things you liked more about living with your mom who died, and things you like more about living with your mom and dad and Cassie?	Facilitator notes that his own opinions about which life might be better for Hayden are starting to come up. Facilitator uses this question to explore Hayden's opinions about the differences.
H: Well . . . I think I like living with mom and dad better because they don't yell at me.	
F: You really like it that they don't yell like your mom did, so you like that part better about living with them . . .	
H: Yeah . . .	
F: Is there anything that you liked better about living with your mom who died?	Facilitator interprets Hayden's pause to mean that there's more to say.
H: Umm, well, my mom used to read me stories at night, and she had the best voices for all the different animals. My mom and dad now don't do that.	
F: Your mom could make different voices, but your mom and dad now can't—that's something you really miss about your mom who died.	Facilitator offers a possible meaning ("You miss that about your mom") to see if it fits with Hayden's view.
H: Yeah, I miss that a lot.	Hayden confirms that this view is accurate.

This dialogue between the facilitator and 8-year-old Hayden is an example of how adults can use reflective communication and curious questions to help a child unfold his or her story. The reflection serves as an invitation to the child to say more, without having to correct the adult's interpretation, while the questions allow the child to think about the many ways his or her life has been affected by the death. Grieving children often don't have people or environments in their lives where they can share their opinions about death and grief without being told that they should think, feel, or act differently.

CONCLUDING COMMENTS

In our experience, working with children and grief involves engaging them at some level in the concept of process—whether that process is verbal, physical, or creative (see Figure 9.5). We work to engage them enough so that they are able to find one or many ways to move within the experience of grief. This engagement may be generated by an individual therapist, within the context of a family therapy, or by other participants in a peer support group. A child who comes to a therapy session or to a group meeting to see and play with "friends" is a child who feels comfortable in an environment that is grief-focused. While these children come to our offices and our programs to play and have fun, they do so in a context that is grounded in the concept of loss.

In our program, we teach volunteers the skills of awareness, reflection, conversation, and group cohesion, in an effort to help them learn best how to create

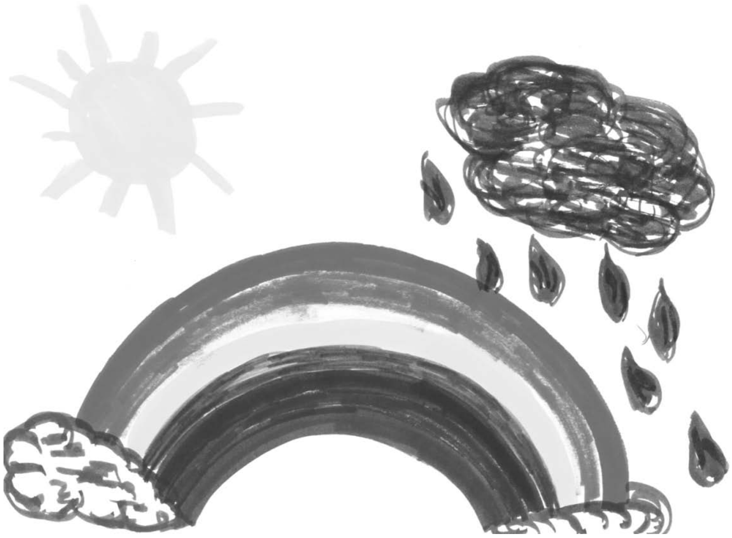

FIGURE 9.5. Rainbow with sun and clouds: A common art theme for children at The Dougy Center.

alliances with the children and adults who attend our groups. These same skills are useful in the many settings in which helping professionals work with grieving children. They also allow us to create a setting in which children are able to conduct the process of making meaning out of the death. Our approach is one way that enables children to lead their own meaning-making process after a death.

Study Questions

1. In learning about our model for working with grieving children, what differences do you note between it and more traditional grief therapy approaches? How would you incorporate these concepts in your current practice?
2. In working with a bereaved family, how would you support members who have different or conflicting ways of dealing with their grief and/or making meaning out of the death?
3. As we have all experienced loss in our lives, what areas or topics to do you foresee being "hot spots" for you in working with grieving children? What impact do you imagine these hot spots will have on your ability to let children lead their own process?
4. Looking back at the facilitator's interaction with Jackson after finding the dead mouse, which parts did you think worked well? Which parts might you have changed or phrased differently?

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RESOURCES

Play Therapy Supplies

The Child Inside: *www.thechildinside.com*
Child Therapy Toys: *www.childtherapytoys.com*

Books for Children

Ages 3–6

Brown, L. K., & Brown, M. (1996). *When dinosaurs die: A guide to understanding death*. Boston: Little, Brown.

Silverman, J. (1999). *Help me say goodbye: Activities for helping kids cope when a special person dies*. Silver Spring, MD: Fairview Press.

Thomas, P. (2001). *I miss you: A first look at death*. Hauppauge, NY: Barron's Educational Series.

Ages 7–10

Eldon, A. (2002). *Angel catcher for kids: A journal to help you remember the person you love who died*. San Francisco: Chronicle Books.

Goldman, L. (1998). *Bart speaks out: Breaking the silence on suicide*. Los Angeles: Western Psychological Services.

Romain, T. (1999). *What on earth do you do when someone dies?* Minneapolis, MN: Free Spirit.

Ages 10–13

Cosby, B. (2000). *The day I saw my father cry*. New York: Scholastic.

Dennison, A. (2003). *Our dad died: The true story of three kids whose lives changed*. Minneapolis, MN: Free Spirit.

Dower, L. (2001). *I will remember you: What to do when someone you love dies*. New York: Scholastic.

Books for Professionals and Other Adults to Help Grieving Children

Dougy Center. (2000). *35 ways to help a grieving child*. Portland, OR: Author.

Dougy Center. (2005). *Waving goodbye: An activities manual for grieving children*. Portland, OR: Author.

Schaefer, D., Lyons, C., & Perez, D. (2002). *How do we tell the children?: A step-by-step guide for helping children two to teen when someone dies*. New York: Newmarket Press.

Wolfelt, A. (1996). *Healing the bereaved child: Grief gardening, growth through grief and other touchstones for caregivers*. Fort Collins, CO: Companion Press.

Chapter 10

Living Beyond the Crisis of Childhood Cancer

Robin F. Goodman

Once a child is diagnosed with cancer, the potentially life-threatening illness forever impacts a child and family in unique and challenging ways. Mental health professionals have the opportunity to help children and families navigate the medical crisis of cancer and learn how to incorporate the disease and related experiences into the changed fabric of their lives. Although there are numerous forms of cancer affecting specific individuals differently, having a psychologically and physically healthy outcome is the goal for all. Helping a child accomplish this, a mental health professional is required to be well informed about the disease process and treatment, to assess behaviors that are reactive to the medically related situation, understand factors unique to each child's personality and family's way of functioning, identify strengths of the individual and family system that can be bolstered, and address perceived vulnerabilities to prevent future difficulties.

By definition and function, cancer destroys. Psychotherapy promotes constructive development by building cognitive, social, and emotional resources. Children can be, and are, resilient—as these comments from young adult survivors of childhood cancer indicate: "I just got married and I hope we can have a baby," "When I had cancer, it was like someone pressed a pause button, but then I kept going," and "I'm going to be a doctor so other kids don't get it."

We now understand resilience as "ordinary magic" (Masten, 2001), although on a pediatric cancer service it often seems quite extraordinary. Asked how her life was different from others' because she had cancer at age 8, a 20-year-old survivor couldn't answer. She could not conceive of or know of a life without it. Having cancer was a fundamental piece of her childhood, integrated into who she was, just as having a brother and being on the basketball team were.

Having long hair, losing it, and having it back again were intrinsic to her identity. This is not meant to minimize the experience, but to illustrate how children can successfully cope with the "crisis" of growing up with cancer. "Crisis" as a label does not tell the whole story. For those who have cancer, it may more appropriately be considered a complex and challenging journey. This chapter discusses the story of one child and his family as they walked (and continue to walk) through life with childhood leukemia. It provides vignettes of selected significant moments, problems, and triumphs from the diagnosis at age 6 to a disease-free stage in college.

EFFECTS OF CANCER ON CHILDREN

Whereas in the 1960s only 20–30% of the children diagnosed with cancer were expected to survive, today the 5-year survival rate when all cancers are combined for children through age 14 is 79%, and it is as high as 94% for children with Hodgkin lymphoma (American Cancer Society, 2004; National Cancer Institute, 2004). "Over 11,000 children are diagnosed with new cancers each year in the U.S." (National Child Traumatic Stress Network, 2006), and by the age of 20, 1 out of every 1,000 adults is a survivor (Granowetter, 1994). Despite the more optimistic outlook, however, cancer is the leading cause of death by disease in children under age 14 (American Cancer Society, 2004).

In many ways, cancer can be considered a chronic disorder, which by definition can go on for some time, have events requiring intensive medical intervention, may or may not be fatal, and can result in a relatively normal lifespan even though there may be resulting physical or mental impairment. (Mattson, 1972). However, unlike an acute illness, cancer requires management over long periods of time, and the responsibility for the management of the illness is shared with and/or transferred to the child and family (Wallander & Thompson, 1995).

As the survival rates for pediatric patients with cancer have increased, interest in the emotional impact of cancer has increased likewise. Psychological research has dovetailed with the change in prognosis. Medically, the focus has now shifted from managing the early crisis of the diagnosis to managing cancer throughout life. Outpatient treatment and even at-home treatment have long been routine for children with cancer, with hospitalization limited to the initial diagnosis, administration of certain drugs, and complications such as infections. As a standard part of their care, most children are also assigned to a "late-effects" clinic, with specialists in the long-term physical, cognitive, social, and emotional consequences of the disease.

The research reveals both a brighter future and some conflicting results concerning the emotional adjustment of survivors of childhood cancer. The first studies, done retrospectively with survivors, were cautionary. In the late 1970s, O'Malley, Koocher, Foster, and Slavin (1979) reported that 59% of a sample of survivors with a mean age of 5 years, 7 months at diagnosis were "judged to be impaired psychologically" (p. 162). The most common areas of difficulty were

> internalizing problems (anxiety, depression, fear, hopelessness, helplessness, loss of control, frustration), externalizing problems (aggression, noncompliance, withdrawal), somatic complaints (pain and impaired functioning), self-concept issues (poor self-image, low self-esteem, changed or negative identity), social and educational difficulties (academic and learning problems, decreased or deficient social competence). (Goodman, 2001a)

Distress in pediatric patients with cancer has been related to traumatic procedures (such as bone marrow aspirations), severe cosmetic changes, physical appearance, late neurological effects, restrictions in daily activities, and death of fellow patients with cancer (Bennett, 1994; Butler & Copeland, 1993; Natterson & Knudson, 1960; Varni, Katz, Colegrove, & Dolgin, 1995). The potential source of problems includes the following:

> the experience of cancer per se, aversive treatment . . . disruption of children's accustomed and expected daily routines . . . and social relationships, cultural attitudes toward having cancer, how children understand the uncertainties associated with having cancer, the financial burdens on the family, the chronic condition of cancer survivorship, or some combination of these inherent and exogenous factors. (Bearison & Pacifici, 1984, p. 268)

A newer line of research conceptualizes problems and adaptation to cancer within a traumatic stress framework (Kassam-Adams, 2006). According to the most recent criteria for posttraumatic stress disorder (PTSD), a child needs to experience, witness, or be confronted with an "event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (American Psychiatric Association, 2000, p. 467). Despite the fact that survivors of childhood cancer are emotionally healthy and have low rates of PTSD (Phipps, Larson, Long, & Rai, 2006), a subgroup show symptoms of PTSD (Kazak et al., 2004, 2006), related more to subjective than to objective threat appraisal (Stuber et al., 1997). Schwartz and Drotar (2006) found young adult survivors to have a higher rate of PTSD than healthy peers, but no significant differences in other areas, such as on measures of depression and psychosocial quality of life. A more accurate and integrative way to understand pediatric cancer is via a model of "pediatric medical traumatic stress . . . a set of psychological and physiological responses of children and their families to pain, injury, serious illness, medical procedures, and invasive or frightening treatment experiences [including] traumatic stress responses, such as arousal, reexperiencing, and avoidance, which can vary in intensity and may become disruptive to functioning" (Kazak et al., 2006, quoted in National Child Traumatic Stress Network, 2006). Key to working with children is being sensitive to how these influences can lead to what I view as "derailments of developmental tasks."

It is important to keep in mind that, in fact, typical responses and "aspects of traumatic stress reactions are not only normative but adaptive. Though distressing, these reactions may be part of naturally occurring processes of psychological recovery after an extreme experience" (Kassam-Adams, 2006, p. 337).

One must be vigilant about detecting and minimizing the severity and permanence of problems. Yet there is a danger of inappropriately assuming that all patients with cancer react pathologically or abnormally to their disease. Criteria used to assess pathology and normality in healthy groups cannot be transferred to this group in a wholesale fashion (Van Dongen-Melman & Sanders-Woudstra, 1986). The so-called "pathological behavior" of a patient with cancer may in fact be adaptive. We have come a long way in both the medical and psychological care of these patients. Additional evidence conflicts with the prediction of a stormy emotional outlook for survivors of childhood cancer. There are ample data to suggest that children with cancer are no more depressed than other children (Kasitani & Breedlove, 1994), and that some survivors can be as socially well adjusted as their healthy peers with respect to education, vocation, marriage, and interpersonal relationships (Dobkin & Morrow, 1985–1986; Noll et al., 1997).

Even more encouraging is the idea that survivors may do *better* than healthy peers in some areas. Hampel, Rudolph, Stachow, Lab-Lentzsch, and Petermann (2005) found that school-age children with cancer coped with everyday stresses better than control subjects did. This should come as no surprise, given that a child or teen with cancer has already endured and triumphed over one of life's most dramatic events. Especially relevant is the concept of "posttraumatic growth" (Barakat, Alderfer, & Kazak, 2006). Interestingly, children diagnosed after age 5, and those who perceived the most severe life threat, showed the most growth. Perhaps psychological growth is related to an understanding, awareness, and appreciation of life in general and what it takes to survive. Acquiring coping skills and developing a balanced and optimistic perspective on life might also be likely to fuel posttraumatic growth.

UNDERSTANDING, IDENTIFYING, AND ASSESSING SIGNIFICANT FACTORS

Various medical, physical, emotional, cognitive, developmental, cultural, social, and family factors contribute to a child and family's reaction and successful psychological adaptation and adjustment to cancer. Of particular note are the following spheres of influence (Goodman, 2001a; National Child Traumatic Stress Network, 2006):

1. Suddenness of the disease's onset.
2. Severity, course, intensity, frequency, and length of the cancer-related experiences, including painful procedures and threat of recurrence.
3. The degree to which the cancer impairs the child's functioning, and the visibility of the disease.
4. Interference with non-illness-related aspects of life.
5. Involvement of the brain, which can affect cognitive and social functioning.
6. Prior and concurrent traumas, posttraumatic stress, and anxiety.

7. Family functioning.
8. Individual characteristics and internal resources of the child.
9. Demographic variables such as age, gender, and socioeconomic status.
10. External resources and support.

Life with cancer for the child and family can be roughly divided into three broad phases organized around medical events (Goodman, 2001b; National Child Traumatic Stress Network, 2006): (1) the initial diagnosis and beginning of treatment; (2) ongoing treatment aimed at maintaining remission of the cancer; and (3) the end of treatment, with the hoped-for (yet not guaranteed) outcome being a lifelong disease-free state. The following emotional responses are expected to accompany these phases (Clements, Copeland, & Loftus, 1990; Goodman, 2001b; Rowland, 1989):

1. An initial state of shock, fear, sadness, anger, worry, and guilt ensues, resulting from the surprising and life-threatening nature of the disease. These feelings can coexist with learning, intense activity, and attention to new details. The goals are mastery of new information and skills, along with a reordering and reorganization of life.

2. The child and family must deal with painful and upsetting as well as life-saving procedures and treatments. Ideally, the child and family gradually move into a state of adjustment, acceptance, or at least resignation. New routines are established, and even unpredictable disease-related events become less disruptive. Amidst feelings of disappointment, frustration, and fatigue, flashes of normality return, and a sense of hope emerges.

3. Ending treatment, even when it has been successful, can provoke a sense of anguish and worry about relapse as well as relief. Loss of medical and emotional support can cause unexpected sadness as well as gratitude. Reexperiencing of cancer-related fears may erupt, and other life issues that have been put on hold may come to the surface. Relationships with other "cancer families" are also likely to change. A final task, and sometimes struggle becomes one of gradually replacing the identity of a stricken victim with one of a healthy survivor. The psychological and physical late effects of the disease may influence a child and family, and be remembered, throughout life.

DEVELOPMENTAL CONSIDERATIONS

The age of the child and the stage of the disease both have a bearing on the psychological tasks facing the child. At different ages, a child is likely to have specific fears related to hospital and illness experiences. In general, through age 6, a child's biggest fear is separation. This can lead to feelings of abandonment, withdrawal, and mistrust. From age 6 to age 9 or 10, the fears of intrusion, mutilation, and punishment are dominant. The range of reactions at this age can include feelings of rejection and isolation from peers and family, guilt, inadequacy, insecurity, and loss of a sense of mastery. From age 9 or 10 to age 12, the primary fear is loss of bodily functions; the "adult" fear of the possibility and permanence of death also begins to be important at this time. Some consequences of illness disruption at this age are feelings of social isolation, difficulty with intimate relationships, increased dependence, body image concerns, and religious questioning (Astin, 1977–1978; Cook, 1973; Easson, 1974; Holland & Rowland, 1989; Lonetto, 1980; Spinetta, 1974).

Two psychological issues figure more prominently for children with cancer: separation/loss and control/competence (Brunnquell & Hall, 1984). Loss associated with death has often been the focus in the literature on cancer, at times overshadowing a focus on other significant losses (Van Dongen-Melman & Sanders-Woudstra, 1986). Children with cancer must also cope with real, concrete losses (such as the loss of hair or limbs), as well as less observable losses (such as the loss of relationships or independence). Although dealing with separation is a developmental task, having cancer can bring this issue into focus because treatment necessitates prolonged or frequent separations from family and friends, which may encourage heightened dependence on a parent. As a consequence of the disease, it is not unusual for a child to feel as if his or her life is in the hands of others. The resulting loss of control "may disrupt both social and emotional development" (Worchel, Copeland, & Baker, 1987, p. 26). The interaction between the psychological and the physical is difficult to differentiate but imperative to integrate.

CHILDREN'S UNDERSTANDING OF DEATH

Childhood cancer remains a potentially life-threatening disease, and although death is still a taboo topic, children are inquisitive about and wrestle with the concept. There is some consensus on the stages children traverse on their way to a mature understanding of death. By age 9 or 10, they understand that once a person is dead the body no longer functions, and that death is permanent, is irreversible, happens to anyone, and can happen at any time (Anthony, 1971; Bibace & Walsh, 1979; Goodman, 1989; Kastenbaum, 1967; Koocher, 1973; Nagy, 1948; Reilly, Hasazi, & Bond, 1983; Orbach, Gross, Glaubman, & Berman, 1985; Speece & Brent, 1984; Spinetta, 1980; Wass, 1984; Webb, 1993, 2002).

It is important to keep an eye out for developmental differences in understanding. For example, school-age children are apt to be more aware of and scared of death than toddlers are. And as a child undergoes years of treatment, earlier conceptualizations created when the child was cognitively less sophisticated may have lingered, needing to be corrected with more mature (but still age-appropriate) information.

Much has been written about how children with cancer become aware of their disease and its fatal potential. According to Bluebond-Langner (1978), children with cancer go through five stages on their way to becoming specifically socialized about their illness, progressing from learning that their disease is serious to knowing that death is possible if the medicine does not work. Bluebond-Langner (1978) also believes that a child's self-concept corresponds to the different stages. For example, at the stage when children learn the names of the drugs they take and their side effects, they may consider themselves seriously ill, but also conceptualize that they can get better. These different levels are apparent, for example, when parents and professionals are seeking compliance with medical regimens.

GOALS OF INTERVENTION AND PREVENTION

Intervention and prevention for pediatric patients with cancer vary in their focus (e.g., symptom management, emotion regulation); type (e.g., educational video, play therapy) (Beale, 2006); timing (e.g., at, during, or after diagnosis); and format (e.g., individual, family, group). According to Drotar, Crawford, and Ganofsky (1984, pp. 233–265), the main goals include the following:

1. Decrease and mastery of pain, distress, anxiety and fears related to the illness and its management.
2. A developmentally appropriate understanding of the illness.
3. Compliance with treatment regimens.
4. Integration of the illness into family life, including a balance between the needs of other family members.
5. Successful adaptation to the important systems, such as the hospital, school, and peers.

Any model of intervention must account for the changing needs of the child and family, which correspond to and are often driven by the unreliable medical landscape. Hence intervention may have different components and is difficult to manualize. Some intervention is situation-specific, such as less formal psychological first aid delivered in the immediate days and weeks after the initial diagnosis. Other components may be more formal and unique to the child and family. They may be delivered in a fluid manner and repeated as needed, such as specific behavior management techniques that can be taught during periods of chemotherapy-related distress (Morison, Bromfield, & Cameron, 2003), or techniques that aim to enhance self-efficacy and social skills (Harbeck-Weber & McKee, 1995).

KEY ELEMENTS AND FUNCTIONS OF INTERVENTION

Clinically based and research-informed practice highlights the following four intervention models (Goodman, 2001a; Holland & Rowland, 1989).

Education

> Giving patients and families the opportunity to talk about their concerns and receive information about their experiences is critically important. Being able to anticipate stressful events . . . can lessen the emotional drain even though the actual experience has not been altered. . . . Supportive information giving, facilitation of communication among family members, and encouraging discussion of emotional issues [are deemed extremely important to patients and families]. The patient and family members must feel cared about and must know that all their questions will be answered directly and honestly. (Koocher & O'Malley, 1981, p. 175)

Information can empower children and caregivers to become allies with the medical team.

There must be open, honest discussions about the disease and about death with the child and family (Bluebond-Langner, 1978; Goodman, 1989; Vernick & Karon, 1965; Koocher & O'Malley, 1981; Spinetta, 1974; Slavin, O'Malley, Koocher, & Foster, 1982). "Mutual pretense" (Bluebond-Langner, 1978) refers to the adult avoiding discussions of death or looking the other way; adults may assume this stance due to their own anxiety, which encourages a child to do likewise. Children can become lonely when they are aware of their diagnosis, when things are kept secret, and when reality is sugarcoated (Binger et al., 1969). The question is not *what* to tell children about death and illness, but *how* to tell them. This is done by providing developmentally appropriate information, clarifying misinformation, picking up cues about feelings and fears, and responding to these rather than avoiding them.

Cognitive-Behavioral Strategies

Coping aims to reduce the stress resulting from discomforting emotions and situations. A child's stages of cognitive, emotional, and personality development, as well as illness-related factors, influence the type and flexibility of coping strategies used (Schmidt, Petersen, & Bullinger, 2003). Research has shown success with interventions addressing adverse disease- and treatment-related issues, such as pain management, procedure-related distress, and psychosocial adjustment. Cognitive-behavioral therapy, including such common techniques as identification of feelings and problem solving (see, e.g., Medical University of South Carolina, 2005), as well as behavior modification and relaxation/imagery (Kibby, Tyc, & Mulhern, 1998)—are the approaches most frequently and successfully used to change the way children and teens with cancer think, feel, and behave.

Working with pediatric patients who have cancer involves helping them feel less scared, experience less distress during painful procedures, manage upsetting feelings and side effects, and develop mastery and control (Manne, Redd, Jacobson, Garfinkel, & Schorr, 1990). Technology is opening up exciting new avenues for future intervention, including the use of CD-ROM training to improve coping (Bisignano & Bush, 2006).

Family Therapy and Group Work

Children must be seen in the context of their total interpersonal environment. Cancer can be an all-consuming and isolating experience, affecting individuals within the immediate family and the child's extended social world. Hence it is important to attend to those who are affected and can be used as resources for support (Schmidt et al., 2003; Drotar, 2005). We know that family functioning contributes to the functioning of ill children (see, e.g., Bonner et al., 2006), and that children do best when their parents are doing well. Parents, more than children, seem to be at risk for stress. Between 6% and 40% of parents of children with cancer have been shown to have symptoms of PTSD when compared to parents of healthy children or those with diabetes (Fuemmeler, Mullins, Van Pelt, Carpentier, & Parkhurst, 2005; Phipps et al., 2006; Kazak et al., 2005). And the risk persists, especially for reexperiencing and avoidance, even years after children have finished treatment (Fuemmeler et al., 2005).

Children are never more dependent on their parents then when managing illness. Parental functioning has been shown to negatively influence that of a child. For example, parent anxiety resulted in less success with a distraction intervention for injection (Dahlquist & Pendley, 2005). When caregivers are doing well, they can parent better, relieve a child's guilt and anxiety about the parents, and model appropriate coping for the child. Siblings are the sometimes forgotten witnesses and survivors of cancer. They often feel vulnerability, jealousy, guilt, worry, fear of the ill sibling's dying, and a sense of heightened responsibility (Chesler, Allswede, & Barbarin, 1991; Sargent et al., 1995), and may be at risk for PTSD themselves (Alderfer, Labay, & Kazak, 2003).

Attempts at standardizing interventions have featured structured work with family groups. Kazak et al. (2005) propose an assessment and treatment package for the whole family based on the different phases of the cancer experience, in keeping with the pediatric medical traumatic stress model. This package is focused on alleviating immediate distress and preventing future difficulty by providing information and normalizing experiences, addressing unhelpful beliefs, building skills to manage physical symptoms and emotional reactions, and preparing family members for possible later challenges (Kazak et al., 2005, 2006).

Peer relationships are especially critical for children with cancer. Social interaction via formal group meetings and school activities, or informally via such online support communities as Starlight Starbright Children's Foundation, reduces the physical and psychological isolation that accompany the disease. Connecting children and family members with each other, in addition to helping them navigate relationships with the "healthy" (non-cancer-related) world, is important (Morison et al., 2003). School represents an obvious normalizing environment. Reentry into the academic and social arenas is essential (Sexson & Madan-Swain, 1993), but it can come at a cost to young patients with cancer, especially with respect to social competence and behavior problems. A child's physical limitations, disfigurement, or learning problems can magnify the difficulties (Mulherns, Carpentieri, Shema, Stone, & Fairclough, 1993; Shelby, Nagle, Barnett-Queen, Quattlebaum, & Wuori, 1998). Hence a child's interaction with the peer group via social and educational activities needs to be monitored and supported.

Expressive Techniques

Adams-Greenly (1984, p. 63) refers to Sourkes (1982), who "pointed out that children often have two versions of an illness; the medical version, which they can repeat verbatim, and their own private version . . . play, art, drama, and casual conversation are all useful tools in ascertaining the child's private perceptions." Moreover, "Finding an acceptable outlet for feelings of anxiety, anger, and fear and gaining a sense of mastery over the environment have been identified as important coping tasks among seriously ill children" (Koocher and O'Malley, 1981, p. 10). Nonverbal techniques provide not only comforting and familiar communication avenues for children, but means for clarifying reality and dispelling fantasy. Play and art provide opportunities to turn the passive into the active, and allow for emotional release, reorganization, and reexperiencing of problems and anxiety (Petrillo & Sanger, 1980, p. 160). Through play therapy, the child is able to find solutions and enact feelings without fear of criticism (Webb, 2003).

Art can be a powerful tool in discovering a child's concerns. By creating art, ill children are being constructive in the midst of a life that entails destroying the part of them that has disease. Children can create their own artistic symbols to express feelings, in contrast to taking a ready-made play object and projecting feelings onto the toy. The artwork is more personalized and allows a therapist to talk in a nonthreatening way, using a child's own metaphors (Kramer, 1993; Rubin, 2005). Diagnostically, drawings may reveal how a child is coping with such physical changes as loss of hair or an amputation; therapeutically, drawings can be used as a method of intervention. Of course, throughout the therapy, interpretation of drawings and assessment of a child must always include more than one piece of art. One must consider the body of work, the child's own explanations, and the context in which the art was produced.

Common themes emerging in the artwork of children with cancer include illustrations of disease-specific issues, especially those related to loss and change (Sourkes, 1982). Once diagnosed with cancer, children may feel they have lost their identity, and their self-image may be altered to accommodate aspects of their disease. Figure drawings by children with cancer can provide clues to how they feel about being labeled "sick." Children feeling a loss of control may portray their anger in the form of superhero battles, or may attempt to regain a sense of control by realistically depicting various medical situations.

Once diagnosed with cancer, children often experience lost or changed relationships. Time with peers and family members is frequently altered because of the temporary effects of treatment, and fellow patients may die of their disease. Thus children may fear the loss of their own lives, and may feel helpless or hopeless in reaction to (and as a way of coping with) their feelings about illness and death. Or their art may reveal renewed religious beliefs, or faith that parents and staff members can help them in their struggles.

THE CASE: TIM BRADLEY, AGE 6

Family Information

Tim Bradley was a 6-year-old boy in first grade, the second child of a white, middle-class family. He had one sister, Rebecca, age 9, who was in the fourth grade. Both parents were college-educated. Mrs. Bradley, age 35, had stopped working when her daughter was born, and Mr. Bradley, age 37, was an attorney. The paternal grandparents were alive and were involved with the family. Although they lived out of state, they moved in with the family for 4 months to help out when Tim was diagnosed. A maternal aunt also routinely provided babysitting and companionship for the children.

Presenting Problem

Tim was diagnosed with leukemia at age 5, after a month of easy bruising and flu-like symptoms. Up until that time, he had been in good health and had suffered only the usual childhood ailments (such as sore throats and chickenpox). Until Tim was diagnosed with leukemia, the family had not experienced significant stressors or traumas. There were no signs of previous family psychopathology. The diagnosis challenged the family system, however, and weak links in the parents' communication patterns emerged. In addition, the child and his family had to deal with the tangible, technical aspects of the treatment regimen and with the associated emotional reactions and fears surrounding the disease.

I had gathered background information about Tim's disease and medical treatment from the physicians, and had a preliminary meeting with his parents to obtain their report on Tim and a general assessment of the parent's initial reactions and past and current family functioning. The following account provides examples of an integrated cognitive-behavioral and art-therapy-based approach with Tim.

Structure of the Pediatric Oncology Service

The mental health staff composition and structure of pediatric oncology services vary, with many having some combination of psychiatrists, psychologists, education specialists, social workers, child life specialists, creative arts therapists, and recreation therapists, in addition to medical doctors and specialized nurses. Hence, although certain training and expertise dictates that particular interventions are delivered by those appropriately trained, the interventions may be determined by function rather than strictly by profession. Treatment planning is best carried out in a collaborative manner, in keeping with best practices. My role with this child and family was as a psychologist and art therapist.

First Interview with Tim

I met Tim on the fifth day of his initial hospitalization, at the beginning of his chemotherapy treatment. During his hospitalization, a steady stream of visitors and family members came in shifts to stay with him. He was already quite knowledgeable about his disease and knew his diagnosis. His hair had begun to fall out because of the medicines, and although he was not quite sure why this was happening, he was not particularly upset by it. For our first session, I arrived with an assortment of drawing materials and hospital play supplies. I explained that I was a different kind of doctor, and that I came to find out how he was feeling and see whether he had any questions or complaints. I also said that sometimes talking or drawing helped children to feel better.

When I arrived, Tim was looking for the box he had been using to save his hair. Being unable to find it, I offered to wrap up strands of his hair in a paper towel. Then I suggested he decorate the towel so that everyone would know it was special and would not mistakenly throw it out. He drew a happy face on the toweling and then went on to color another picture. He talked about all the "sticks" (blood tests and intravenous lines) he was getting and what he did to get through them. He explained that his mother was at home sometimes to take care of his sister, and if he was alone at night and got scared, he could call his father. When Tim was hospitalized, Mr. Bradley slept at the hospital or with friends nearby, coming to the hospital whenever he was summoned by Tim. Knowing how to get help, and how to use social supports in general, can be extremely important for a child's well-being. Confidence and trust in parents have been associated with positive adaptation in children with cancer (see, e.g., Worchel et al., 1987).

Tim's prior functioning had been excellent. Until his diagnosis, he had enjoyed a life free of traumatic events. This was evidenced by his apparent physical and psychological strength, resulting in a rapid adjustment to treatment. He was cooperative; he engaged well with staff members; and his initial psychological prognosis was good. However, he had much ahead of him.

First Interview with Parents

The initial conversations with Mr. and Mrs. Bradley were educational, focused on normalizing their fear of bringing Tim home for the first time. This can be a frightening experience, one for which parents feel ill equipped. I likened it to bringing a newborn first child home, reassuring them that the medical team sent families home only when they were ready, and making sure the parents had plans in place for what they faced. Since the goal was for Tim to resume his usual activities as much as possible, including going back to school, I provided them with a handout designed for school staff describing common issues related to school reentry for when Tim returned. The parents met with Tim's teacher and the school nurse to ensure a smooth transition after discharge. Indeed, Tim returned to school in a month, with no apparent problems. All of his chemotherapy was administered on an outpatient basis, which clearly encouraged his getting back to a routine. Gaining a sense of normality instills hope.

Tim was a charming patient, managing quite confidently and independently. His positive attitude was a reflection of the philosophy his parents displayed. They were careful to shield Tim from their own anguish and doubts. Such mutuality between parents, and their ability to maintain stability in the early stages of the disease, can reduce a child's fear and hopelessness (Rowland, 1989).

An Early Intervention: Tim's List of Coping Strategies

Tim coped by being in charge and preparing himself for whatever events he encountered at the clinic. However, evidence indicating that he was scared erupted in his laughing and joking when others discussed medical procedures. Using denial and avoidance, he attempted to keep fears at bay. Uncharacteristically, he became upset one day when he had an unexpected bone marrow test. This led to a joint effort on the part of his mother and me to help him feel in control. With our encouragement, Tim dictated to me all the things he did to help him get through difficult procedures. Tim's list is a very good summary of many coping techniques used by children with cancer and their families.

Tim's tips, together with the therapeutic principles underlying them, were as follows:

1. Calm down when the doctor wants to help you.	Stress management; belief in power of doctor to control and cure; fear that something Tim might do could jeopardize the outcome.
2. Find out what is going to happen and why.	Information seeking in order to master the situation; knowledge as a means of empowering Tim and increasing his feelings of control.
3. Take deep breaths.	Relaxation and distraction as portable aids in stress management.
4. Get hugs from Mom and Dad.	Fear of separation and abandonment; use of social support; need to feel safe; increased dependence on parents.
5. Count while the needle is in.	Distraction; active participation to decrease feeling helpless.
6. Think of nice things.	Imagery used for distraction and to minimize negative associations; thought stopping.
7. Think about getting better.	Positive attitude as a way for Tim to feel in control, be partner in cure; learned optimism and hope.

8. It's OK to cry, but never say no!	Appropriate identification and expression of feelings; validation of feelings; limit setting on behavior. Doctors and parents are still in charge.
9. Drink something or do something else.	Need for nurturance, self-soothing, distraction.
10. When you feel sad, talk to Mom or Dad or someone who is there.	Need for outside social support; proactively seeking and using available resources; need for and value of identification and expression of feelings.
11. Tell your friends to ignore that you are sick.	Coping with changed identity; need for normalizing childhood experiences and socialization

Preliminary Assessment and Treatment Plan

The family had confronted head-on the challenges of the beginning phases of medical treatment. The first month or two of intense chemotherapy to induce remission required multiple trips to doctors for medicine and procedures. The family had developed a routine whereby Mr. Bradley took time off from work to accompany Tim, while Mrs. Bradley kept up the usual activities for the children. When treatment required particularly painful procedures (e.g., a bone marrow aspiration and/or a spinal tap), both parents joined Tim. The invasive procedures were the most potentially traumatizing for Tim.

Because of the frequency with which Mr. Bradley was with Tim, he was the first to discuss with the doctor some side effects that Tim was having. Mrs. Bradley felt left out, and this marked the beginning of a difficult time for the couple. In addition to the parents' struggling with sharing their responsibilities, Tim was having temper tantrums at home, in which he would get into fits of anger and be unable to calm himself down. Tim was bothered by his tantrums, and he felt guilty about his behavior. This was highly unusual behavior for him and was probably caused by a combination of the side effects from his steroid medication (routinely used in chemotherapy regimens), a course of radiation therapy, and his general increased frustration with the treatment regimen.

This scenario illustrates some of the typical child and family problems that must be confronted when a child patient's "efforts at autonomy are thwarted [and] anger, repression, and withdrawal may result. The drive to reexert control can lead to increased oppositional behavior (stubbornness) and tantrums" (Rowland, 1989, p. 528). At the same time, parents can be confused about how to handle the situation and require assistance with their tendency to overindulge the child. It is best to encourage social autonomy appropriate to the child's age, combined with reasonable limit setting (Rowland, 1989).

Tim had handled his disease well up to this point, but the signs of stress were becoming evident. In retrospect, his previous "good" behavior was just as much an indication of a brewing problem as was his present "bad" behavior (Rowland, 1989). Older children in particular can feel guilty for getting cancer or responsible for the upheaval in the family, resulting in their exaggerated attempts to handle their experiences. Tim needed to release some of his pent-up anger and learn about the side effects of his medication. In addition, the parents had not yet dealt with their own fears, the stresses the disease had placed on their family and marriage, and the role they each wanted to play in Tim's treatment. Tim would get confused when the parents suggested different techniques to help him during his "meltdowns." Another significant precipitating factor in beginning treatment was that Mr. Bradley had developed ulcers and had been told by his internist that he was not handling his stress effectively.

Psychoeducation about disease-related issues and support for day-to-day management was provided. About 3 months after Tim's diagnosis, a conjoint session with child and parents was held to discuss Tim's outbursts and present a behavioral intervention to improve the situation. With Tim and his parents together, I explained that Tim's episodes were not completely under his control and that they were partially caused by his medication. This education was intended to relieve Tim's feelings of guilt and empower the parents to take control. They had wanted to be supportive of him when he was angry, but also felt sorry for him and were exhausting themselves. He was getting mixed messages, was not responding to their efforts, and felt out of control. The mutual decision was that his frustration and anger should be acknowledged; then they would leave him alone to calm down. After the episode had passed, they all could talk about what had upset him. This resulted in a sense of working together and mutual problem solving. At this point, a plan for the family took shape. Tim would be seen individually for therapy, and the parents would be seen together for counseling sessions. A description (with excerpts) of a 6-month segment of therapy with Tim, and a synopsis of the parent counseling sessions, follow.

Play Therapy Sessions with a Doll

Tim was routinely silly and even talked baby talk at times when he came for treatment or was asked questions about medical procedures. A hospital play session with a doll was used to explore his underlying feelings about different situations.

Content of Session	*Rationale/Analysis*
THERAPIST: Tim, I thought we could play with some doctor equipment. You be in charge and show me what happens when you come here.	Tim is scheduled for a bone marrow aspiration and spinal tap, and I want to prepare him so that he will not be upset or move around, which can interfere with these procedures. Using the doll, I am able to "expose" Tim to the real procedure and desensitize
CHILD: (*Giggles.*)	

T: I brought this "patient" [a gingerbread-type stuffed doll]. Let's work in one of the examination rooms. C: OK.	him. I want Tim to verbalize and act out what may happen for him in the same situation. Practicing with me is safe and nonthreatening; ideally, the behavioral rehearsal and his sense of calm will generalize to the actual situation.
(*Once in the room, child draws a face on the doll with markers and calls the patient doll "Tim." Therapist shows child all of the needles, gauze, swabs, etc., that she has brought. They begin to role-play what happens during a spinal tap.*) T: Why does he need those shots and medicines, anyway? C: To get rid of the leukemia, so it doesn't come back. T: How did he get sick? C: No one knows; he just did, but he can't give it to anyone else.	Since this is an individual session, I let him use some small, real needles; I am careful not to show him particularly large ones, which frighten children. Although I have a policy of being honest with patients, I have found that children become overwhelmed by the sight of actual bone marrow and spinal tap needles. Tim is very familiar with steps for the procedure and takes control while working.
T: You had some great suggestions on the "tip" list that you made. Tell me what "Tim" should do when he gets procedures. C: He should breathe and think about going on his favorite boat ride at Disney World.	Whenever possible, it is best to approximate the real situation as closely as possible to increase the mastery. According to cognitive-behavioral principles, it is also crucial to pair the play and exposure with coping strategies, so that the child experiences calm in the approximated situation. In addition, parents and staff should be informed of each child's particular strategy so that they can join in as needed.
(As child talks further, therapist solicits sensory details about the imagery to make it as vivid as possible, for later use in the form of guided imagery.) T: I think he needs help. Why don't you show him what to do? C: First he has to curl up in a ball; then I have to wash his back with soap; then there's a needle. T: Does it hurt? Is he going to cry? C: It does hurt for a minute, but if you lie still it goes faster. Now he	This role play preparation can take various amounts of time, depending on the child's anxiety and behavior. It may be necessary to develop a particular guided imagery scenario and to practice the scenario over a number of sessions, engaging in closer approximations of the "real" situation over time until the child feels confident. In guided imagery interventions, others may offer embellishments and assist the child with the visual imagery.

gets a Band-Aid and has to lie still for 45 minutes.	
T: How was that?	
C: Good. He was a big help. I want to leave "Tim" here and give him more shots next time.	By being the doctor and acting out the role of the aggressor, Tim is able to release anger and feel in control. With me voicing the possible worries of the doll as patient, he is able to hear me validate his feelings, confront his anxiety, develop mastery, and take on the role of teacher in modeling appropriate coping behavior for me, ending with his practicing directly. I am impressed with his maturity.

During waiting time at the clinic, I also showed Tim and his parents a behavioral training video of a child learning to cope with procedures. We played with the doll twice more in the following weeks. At times, the sequence of details of the reenactments accurately approximated Tim's own experiences; at other times, he gave the patient doll numerous extra injections. At the end of the last session with the doll, he declared that the "patient" could get a year off from treatment, and his attendant anxiety dissipated. Tim had also wanted to bring the doll to school so that his classmates would know what he was going through.

These sessions allowed me to explore, with Tim, his concept of his disease. By listening for any misconceptions or irrational fears, I found that Tim was accurate in his knowledge about his leukemia, to the point of being sure that no one knows why people get it. I also corrected some inaccurate cognitions. Weeks later, his parents reported that Tim had said he was glad he had gotten cancer now, when he was young, because he knew that everyone would get it someday. Mr. and Mrs. Bradley had corrected this misunderstanding, and I followed up in session. Also, it was significant that Tim had always been completely cooperative with his treatments, had not voiced any resistance, and had a positive outlook on life in general. It was only through the doll that I found out that while being compliant, he harbored a wish for "time off" from treatment, but felt guilty about such a wish.

Parent Counseling

At the same time I was seeing Tim individually, couple sessions with the parents continued on a regular basis. When so much of a child's care is taken over by medical personnel, parents can feel helpless and not needed. It is important to reinforce their role by reminding them that their parenting skills are essential, that they know their child best, and that they cannot be replaced by doctors and nurses.

Working with medically ill patients and their families requires flexibility. Issues surfaced that necessitated a change from a family-focused parent counseling approach to help them manage Tim and his sister, to a more marriage-focused approach. The frequency with which they came to the hospital and their familiarity with me made it easier to do everything in one place at one time, rather than scheduling appointments elsewhere.

Tim's parents went through some of the stages typical of parents of a newly diagnosed child. Individually, the mother and father had to confront the reality of not being able to protect their child from bad things, which caused them much guilt as well as anguish. This can be likened to a type of mourning for the hoped-for perfectly healthy child who will have a long and happy life. Childhood cancer highlights both parents' fallibility and their vulnerability. They are faced with enormous decisions when they are feeling most helpless and uncertain (National Child Traumatic Stress Network, 2006). Spouses can be afraid to verbalize and admit their worries to each other, causing them to feel alone in their fear and grief, struggling at a time when spousal support is needed the most. Parents may respond to and cope with their crisis in seemingly opposite ways. For example, one parent may be the emotional one, carrying the burden of containing and/or displaying the emotions, and may cry or become depressed or even distraught for a period of time. The other parent may take charge, appear to be in control, and intellectualize about the disease. It is a complementary system, in which one person feels free to enact a certain role because the other provides balance or ballast. Together, they successfully exhibit and confront the conflicting emotions stimulated by the crisis. In reality, both types of reactions are often emblematic of intense fear.

During the first few months of treatment, the parents were preoccupied with the day-to-day tasks of treatment, such as doctors' visits, blood counts, and oral medications at home. This period of heightened disease-specific activity enabled them to pull together to handle concrete details. Slowly, as the medical aspects became routinized, unsettling cancer-related feelings emerged. Characteristically, between 6 and 12 months after the diagnosis, parents begin to ask "Why me?" and "Why my child?", and they experience a stage of renewed anxiety about their child's chances of survival. They also realize how fundamentally different they are from before the diagnosis and how different they feel from their "precancer" family and friends. Ideally, at this point the child and family begin to put the disease in perspective. They realize that they can never go back in time and must live with the possibility—no matter how remote—of a cancer-caused death. They develop and employ cognitive strategies such as the clichéd but accurate "take one day at a time" approach, learn that the unpredictable is predictable, and choose how to live in their changed world.

Play Therapy Sessions with Journal Making and Artwork

Over the next month, Tim continued to have temper tantrums and developed sleeping spells, labeled "postradiation somnolence." He would doze off at unannounced times and could not be easily aroused. These episodes were usually preceded by irritability and crying without any apparent cause. While he was getting neurological and psychoeducational evaluations, we worked on these problems in therapy by means of journal making and drawing. Through these activities, Tim revealed how disruptive treatment was to his "regular life." He wanted a different appointment time so that he would not miss gym and art. After his parents and I validated his very real frustration and provided encouragement, Tim aired his concerns to his doctor. To Tim's proud surprise, the appointment schedule was changed—a small change with a big impact.

A significant theme in the play sessions such as the ones related to his appointment time, was Tim's ambivalence about negotiating for what he wanted. In a parallel fashion, in the parents' therapy we dealt with their difficulties in confronting staff members, asserting themselves, and making their individual needs known to each other. Parents commonly feel helpless once their child's life is in the hands of "medical experts." There can be tremendous, though usually unrealistic, fear that asking questions or disagreeing will influence their child's care: "What if the doctor or nurse gets angry and takes it out on the child?" Tim was a model for assertiveness. For both medically related situations and broader life events, "families need to regain control back over their lives in the face of the powerlessness they experience" (Morison et al., 2003, p. 129).

Tim's tantrums waxed and waned. One of the focal points in sessions with the parents involved how they could be united in dealing with his outbursts. During one particularly bad incident, Tim impulsively screamed, "I'm no good! I'm dumb and stupid! I don't know my numbers! It's my chemo." He had also recently written a letter to Jason Gaes, the author of *My Book for Kids with Cansur* [*sic*] (Gaes, 1987). He ended the letter, "I hate leukemia." With the parents, I discussed the strains on everyone in the family. The incident and the letter highlighted the need to help Tim deal with the reality of his cancer, as well as his self-image and self-esteem.

A few weeks later, Tim agreed to have a session while he waited for his bone marrow aspiration and spinal tap. The timing of our sessions varied; some were planned, but others occurred spontaneously. But, like the child's life, therapy is most often dictated by the capriciousness of the disease itself.

Content of Session	*Rationale/Analysis*
Child: (*Picks up the Cray-Pas.*) These are great! I get to use these in school. But this is different, because in school I get all the broken ones.	I have brought some new drawing materials (Cray-Pas and special watercolor crayons) for Tim to try. I enjoy giving him things that make him happy, to balance out all the unpleasant experiences. It comes from my own wish to make the situation better. This is a feeling not unlike that of his parents. There is a fine line between spoiling these children and setting firm

	limits. I counsel parents by explaining that the goal is to cure them so they live a long time. Giving in too much can communicate pity, contribute to a sense of doom, or create selfishness. Appropriate discipline is consistent with this message.
THERAPIST: Why? C: I get there last, because the others run up and get them, but they're not supposed to run up.	I am reminded about Tim's issues with self-esteem, and whether he feels left out or different from his peers.
T: So you do the right thing but don't get the good ones? C: It's OK, because they have to share. (*Begins working with white Cray-Pas but stops, saying it will not show up. He begins coloring in the sky with blue. He then draws a green line, a yellow circle, and a black dot, saying it is a flower.*) Guess what it is. It's two words.	I want to address the issue of his needing to be good all the time, especially if he feels in any way responsible for his disease. I also wonder about his trying to fit in with his peers. He has a well-developed sense of morals and a strong, positive superego.
T: Does the second start with S? I don't know.	I encourage playful interaction with me to develop a strong relationship. I want to increase his feelings of competence, but I'm worried I will guess incorrectly and hurt his pride.
C: It's a black-eyed Susan. I'm gonna add leaves. Now I'm gonna start another flower using all different colors. I'll call this one a beautiful-eyed Susan [see Figure 10.1]. T: How do they get along? C: Great.	I wonder if he sees the world or himself as either good or bad. In some instances, it is likely that a child relates to each part of the picture. Thus there may be some aspect of himself represented in both flowers.
T: They look different. C: One's the child and one's the adult. T: What are they doing? C: Holding hands underground with their roots. I need to draw the roots and color in the dirt. If there was another black you could help, but I'm almost finished.	I am trying to have him expand on the meaning of being different or special because of his cancer, as well as feeling isolated from friends. I am also reminded of his feeling guilty about his tantrums. I wonder if the difference is more than just size and age. Perhaps the drawing says something about all the changes Tim has exerpienced.
T: They're holding hands?	I want to explore his relationships with family, peers, or staff members. He has age-appropriate dependence needs and

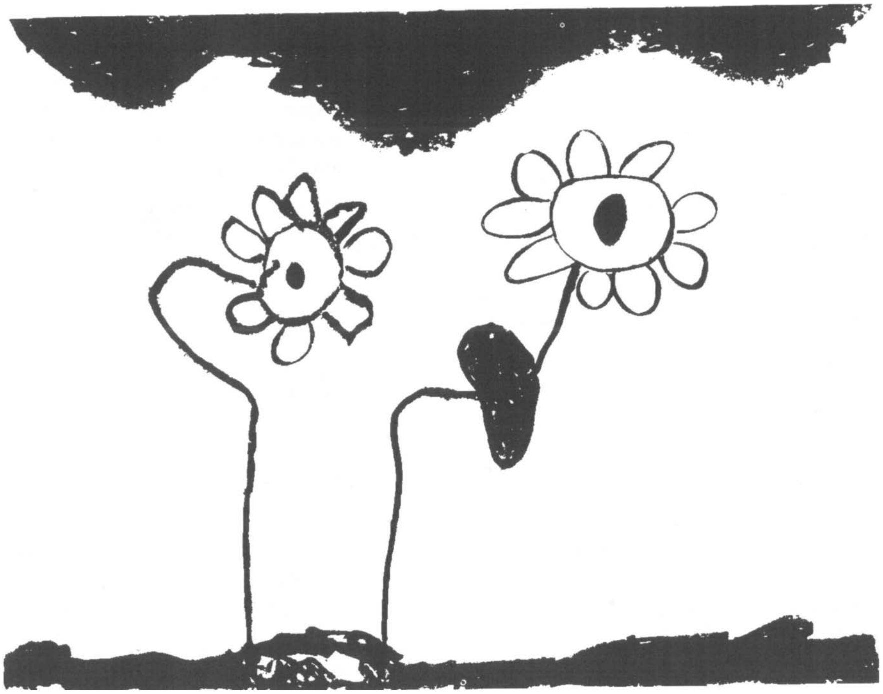

FIGURE 10.1. A black-eyed Susan and a beautiful-eyed Susan.

	expresses his use of his parents as his support system.
C: They can't go anywhere; they're always together. There's a girl in my class, Lizbeth, who draws lots of things; she does the best tulip in the class.	
T: What are you best in?	I encourage reality testing and assessment of his self-esteem and confidence level.
C: People. I'm pretty good at them. I'll show you how I draw different kinds of people. I didn't even know how until I was 5. (*He draws a large stick-like figure on the left side of the page first, then a smaller figure on the right.*) I like the small one better because it has shoulders and a neck [see Figure 10.2].	The two figures in the second drawing are somewhat similar to the two flowers, in that they look like parent and child. I wonder whether he identifies with either figure. The figures are well formed and age-appropriate, but both they and the flowers in the first drawing are linear, and Tim does not fill in the shapes or use all of the space. Also,

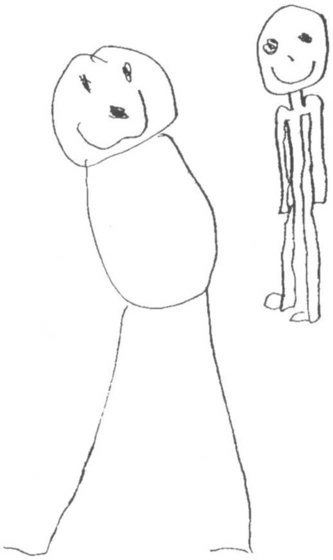

FIGURE 10.2. A parent and child.

T: How are these two different?	they appear bald, and the larger has no arms.
C: Maybe one's on prednisone and one isn't. (*He decides to experiment with the special watercolor crayons I have brought. He makes stripes.*)	I'm surprised by his making such a direct and literal connection to his real experience and weight gain.
C: I'm gonna do lightning. (*He makes green and yellow zig-zags. He tries out different techniques, such as holding a fistful of crayons and drawing lines.*)	Talking about prednisone may have stimulated thoughts about his illness; thus the change to a stormy theme and some anxiety about possible painful procedures.
T: It's fun to experiment sometimes.	
C: Little kids do scribble-scrabble.	I encourage his exploration and loosening of restrictions.
T: Sometimes I do too.	I am supporting his need/desire to be regressive in his play sometimes as an outlet for his tension and anger.
(*Child continues to work, hoping that his counts are low so he won't be able to get his bone marrow and spinal tap procedures, but this will also mean that he won't be able to go to camp.*)	Children of all ages have an impressive knowledge about the details of their illness and how it affects day-to-day life. But having cancer means being special as well, and they accommodate to the good and not-so-good ways.
T: What do you like best about camp?	

C: When it's hot I get special permission to do my favorite activities, hobby and wood shop. But I wish I could make a deal and skip a few treatments, even if it means I have to miss camp.

T: What kind of deal?

C: I would give the doctor all the Ninja Turtle Band-Aids he wants.

T: What would happen if you missed some treatments?

C: It would take longer to get better.

When treatment works and a child feels well, resistance and avoidance can emerge, especially when treatment continues for years. Unpleasant side effects of medicine are the here-and-now problems, rather than any outward, visible signs of leukemia.

Six weeks later, Tim did a pastel drawing (see Figure 10.3).

CHILD: I am in the middle, on prednisone, which is why I'm so big. Dad is on the left, and Mom is on the right . . . they have spinal needles.

He now spontaneously refers to his medical treatment, represents his anger by the needles, and portrays a relationship with his parents. Tim seems to feel surrounded by his parents, able to get their support, and even able to look like everyone else. But he is still aware of how his leukemia and treatment are still part of his life.

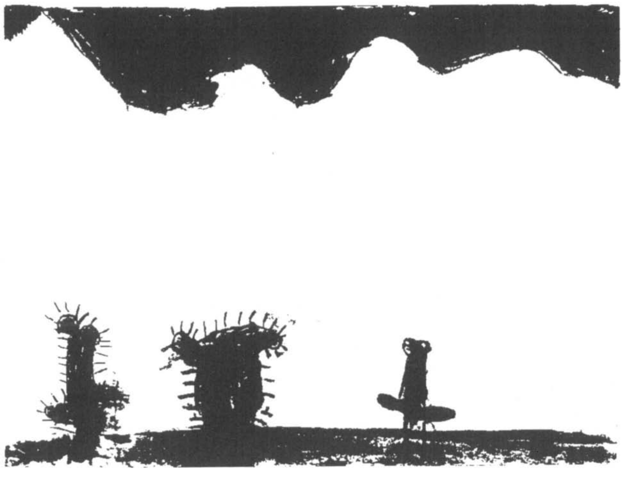

FIGURE 10.3. Cacti: A mother, father, and son.

Tim was now reportedly "back to his old self." Months later, he finished his chemotherapy treatment and the major part of his work with me. Over the last several weeks of this work, he painstakingly drew a still life and painted it (see Figure 10.4), being quite proud of his mastery in art. It was a fitting final tribute—a picture full of the fruits of life—and quite a contrast to the more barren and prickly cacti he had drawn earlier.

COMMENTS

This presentation of a portion of the therapy highlights just some of the typical stresses faced by a child with cancer and his or her family, and points out typical intervention strategies mentioned in the research and clinical literature about childhood cancer (Beale, 2006; Holland & Rowland, 1989). The road can be bumpy and is not a journey anyone would choose. A father of a 9-year-old daughter with lymphoma, who felt blindsided and immobilized by his daughter's diagnosis, said he "couldn't do it." Productive discussion ensued when I explored this and reframed it, saying that he "didn't want to do it, but was certainly capable of doing it quite well." Confronting rather than hiding or avoiding the pain, and summoning the courage to take action, are important and necessary first steps.

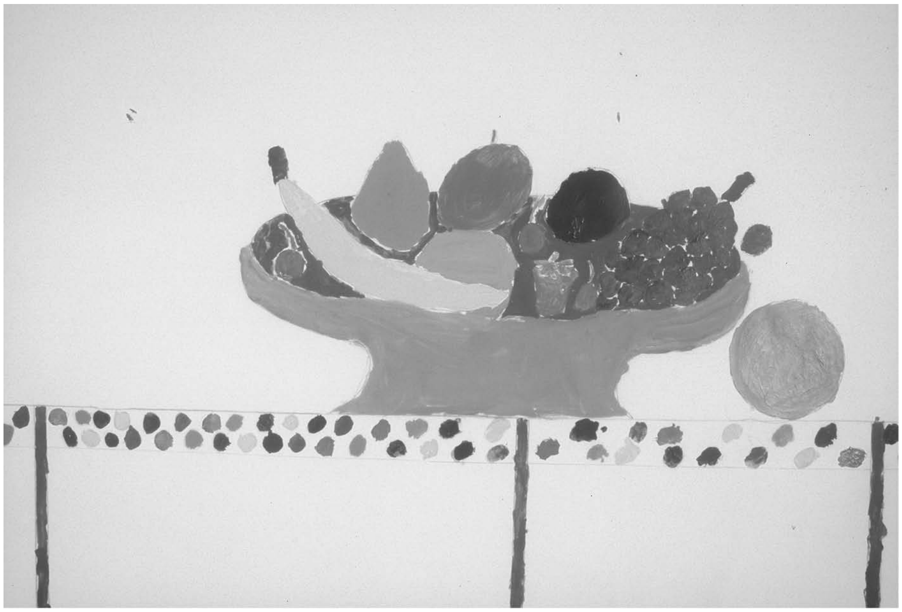

FIGURE 10.4. Fruit bowl.

Tim and his family came to realize that they could not handle all components of his disease alone. The child and family adopted the same ethic—that one could enlist psychological counseling services and art therapy as readily as those of an oncologist in order to improve survival. Tim once coolly suggested to his sister, who was being more than usually annoying during a car trip, that she should "go talk to Dr. Robin." The idea is not to foster unwarranted dependence on yet more "specialists" or "experts." Psychological treatment should be geared toward guiding parents and children to manage their own lives in their own way. The on-site professional becomes a part of the family, and a partner in the care of the child. This engenders a sense of trust and hope that strengthens the treatment alliance.

FOLLOW-UP: TIM, AGE 15

I continued to work periodically with Tim and his family throughout his 3 years of medical treatment, and later had ongoing intermittent contact once the treatment was finished. Tim struggled in school and was diagnosed with a learning disability. Without a precancer baseline evaluation, sorting out the extent to which the learning disability was a consequence of his radiation versus a premorbid problem was difficult. He and his parents used the same determination and perseverance they had demonstrated earlier to get the resources he needed. However, the learning disability contributed to his ongoing sense of being different and special.

Tim eventually made the transition from a school for children with learning disabilities to a local high school, where he became more concerned about finding a spot within the pecking order of peers and girlfriends than with his academic challenges. In addition, he was being followed for decreased heart and lung functions—typical late effects of chemotherapy. In therapy, he became aware of his (as well as his parents') anxiety about secondary medical problems, which tended to be a trigger for some reexperiencing of fears about recurrence and somatization. In addition, he realized his tendency to use physical symptoms as a way to feel important and get attention.

Six years after Tim successfully finished his treatment, I heard about Tim's support of his grandfather as he underwent chemotherapy for prostate cancer, and I gladly helped out Tim's sister when she asked to return to the clinic to do a school project based on being the sibling of a child with cancer. She stood by her contention that she didn't need any special therapy while her brother was sick, but her expressive school project vividly described a sibling who was profoundly affected by the cancer experience. Tim's father still mentions things that he learned from me about his wife, and the couple sought outside counseling when they faced marital problems that were acknowledged to be brewing before the diagnosis. Although it is clear that life has gone on and must go on, I am inextricably tied to a time that forever changed who the Bradleys were as a family.

FURTHER FOLLOW-UP: TIM, AGE 22

Even though new people and events have shaped the Bradleys' lives, we share a time that can never adequately be explained or imagined. Unlike conventional therapy with children with emotional problems, work to help children overcome the effects of a life-threatening illness means that when the children survive, a therapist becomes a therapist "for life." While Tim was in college, Tim or his parents would call me to "consult" on issues that no doubt could be traced to remnants of his cancer days. At one point, Tim returned on his own for individual therapy to deal with issues that continued to hold him back—in particular, his academic performance and social relationships. Although he never lacked friends, his sensitive and caring nature resulted in an often broken heart. He also struggled with coursework and returned home for a semester. He continued to want to excel, but felt that with academics he was always at the back of the pack in a race he would never win. He had great intentions, but would feel overwhelmed, give up, and avoid studying so as not to feel "stupid." Still wanting desperately to be like everyone else, he would be reluctant to get the right help or the accommodations he deserved. He enrolled at a local college and proactively structured resources to help him succeed. Being familiar with his learning history, I supported his getting a tutor, and he implemented study habits and test-taking strategies that we discussed. Although medication for possible anxiety, depression, and attention-deficit/hyperactivity disorder had been tried at various times, he engaged in a methodical and careful trial to find what best fit his needs. He also took better care of himself (e.g., by going to a gym) and was more focused in all areas without the distraction of an active social life. On a number of occasions, I related his current issues to his history with cancer.

For one session, I met with Tim and his father to discuss college and work plans. When the issue of Tim's cancer was raised, his father announced (much to Tim's surprise) that he did not worry about Tim, because he had survived the worst already. He only wanted him to be happy. His parents were proud when people in town commented, "You're Tim's parents? He's a great kid"—a rather sharp contrast to Tim's feeling that he was always "the Bradleys' son with cancer." Tim's adult answer as to why he got cancer was "Bad stuff happens to everyone. I just had mine earlier, and I got it so no one else in the family got it. Now I can enjoy life."

Although there are similarities between other cases of children with cancer and the case of Tim and his family, there are no universal behaviors that can be expected in all such cases. Tim was a confident, engaging boy who continued on his developmental path almost independently of his illness. Some of his strengths were surely related to his good preillness functioning and the support of his cohesive family system. He had the normal fears and anger that any child would have while going through painful and at first confusing experiences. When Tim was diagnosed, his father had left for the night after Tim got his intravenous line put in. Later, in need of a new one, he called his father. Tim was in tears, wanting his father to come back to the hospital.

When Dad arrived, Tim asked him, "Where's God now?" His father, who was having his own difficulty with the question, told Tim that he would need to find his own answer. After being discharged, Tim announced one night at dinner that finally he knew a reason why God gave him leukemia: It was so he would know what it was like to be sick, so he could help other kids. Although they would never choose to have cancer, some children and families can come through the experience stronger, changed for the better, clearer in their vision about the meaning of life. For these patients and families, the crisis can be an opportunity rather than an obstacle.

Study Questions

1. Discuss the stress on therapists of working with children who have a potentially fatal diagnosis. How can such therapists effectively deal with their own feelings about death and dying?
2. Comment on the possible value of a play therapy group for Tim. What would be some of the pros and cons of group therapy compared to individual therapy in a situation of medical crisis such as cancer?
3. There are inevitable stresses on the siblings of a young cancer patient. Discuss how you might have conducted therapy sessions with Tim's sister. How would the initiation of sibling therapy have been discussed with the patient and parents? What issues would have had to be addressed, and what would the goals of treatment for the sister have been?
4. Evaluate Tim's developing sense of self as an adolescent, and predict any possible future difficulties you may envision in reference to his emotional well-being.

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Chapter 11

The Crisis of Parental Deployment in Military Service

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In the aftermath of September 11, 2001, the U.S. military has been increasingly involved in conflicts around the world as part of the globalized war on terror. The family lives of soldiers, sailors, or air personnel involve numerous associated stressors and strains, including frequent relocations and lengthy separations that create incongruency between work and family life (Albano, 1994). Military families often consist of members from various regions of the world and/or different ethnic backgrounds, and one or both parents may have had previous marriages or relationships.

In today's military, it is not uncommon for a child's father, mother, or both parents to deploy. This deployment may be of short duration (such as for a training mission) or for a longer period (such as for sea duty, peacekeeping missions, unaccompanied tours [those without family members], or extended tours in combat zones). Parental separation can have a profound impact on the family in general and on children in particular. The family member(s) in the military may view the deployment as business as usual, but children experience this separation as loss of daily contact with their parent(s). This loss is compounded by the potentially dangerous duty in which the parent(s) may be engaged.

This chapter provides an overview of a family-systems-based approach with children in military families. We begin by discussing pertinent issues for families and children within the military context. In particular, we discuss the family and child stressors specifically associated with the deployment cycle, as well as the occurrence of combat-related trauma in service members and secondary traumatic stress in their family members. Next, an evolving dynamic model for play therapy is discussed by developmental stages and phases of treatment. Finally, we review two cases that illustrate this approach to play therapy with children in military families.

ISSUES FOR FAMILIES AND CHILDREN WITHIN THE MILITARY CONTEXT

Effects of Service on Military Personnel Themselves

Military service renders armed forces personnel more susceptible to a variety of health concerns, including cardiovascular disorders, endocrinological dysfunction, neoplasms, mental illnesses, and substance-related problems (Bray et al., 2003). Among the mental illnesses for which military personnel are at risk, posttraumatic stress disorder (PTSD) in combat troops has been a focus of particular concern for several decades. Evidence suggests that PTSD may be more prevalent among U.S. ground forces serving in Iraq and Afghanistan than previously thought (Hoge et al., 2004). This sample of inpatients, who had experienced a wide range of injuries from combat, reported problems associated with the three major PTSD symptom sets of intrusion, hyperarousal, and affective constriction. Hoge et al. (2004) further suggested that as many as one in six soldiers (17%) were suffering symptoms of this disorder.

Deployment-Related Stress and Problems for Families

No other stressor assails the coping abilities of military personnel, spouses and families like the separations created as a result of frequent deployments (Black, 1993). Regardless of the deployed person's experience, the emotional impact of the separation on parents and their children represents a significant and profound loss for all family members. The involvement in either combat or peacekeeping missions causes considerable stress for family members who remain behind. Separation from significant attachment relationships and the resulting anxiety caused by military deployments often disrupt the daily functioning of children and family members, and create the need for intervention by helping professionals. The increase in length and number of deployments associated with the U.S. military involvement in both Afghanistan and Iraq has caused excessive strain on family members and the various community relationships in which they are involved (Bowen, Mancini, Martin, Ware, & Nelson, 2003). A number of indicators point to a link between the separations caused by wartime deployments and an increase in the emotional difficulties experienced by military families, including the breakup of marriages and families (Ruger, Wilson, & Waldrop, 2002). We discuss the effects of the deployment cycle on the family system more fully in a later section.

The Specific Effects of Parental Separation on Children

The effect of parental absence on children has been an important area of study in the military family research literature. Most of the research to date has been on father absence, although there has been growing interest in mother absence. Father absence has been found to be negatively related to children's behavioral adjustment and academic performance, as well as to increased levels of anxiety and depression (Hiew, 1992; Jensen, Grogan, Xenakis, & Bain, 1989). Children of deployed parents are at risk for increased psychiatric hospitalization rates (Levai & Kaplan, 1995); increased aggression and dependency have also been found in later-born sons, and decreased quantitative ability in daughters (Hillenbrand, 1976). Kelley (1994) found that even routine missions were disruptive to military families to some degree, especially for families with young school-age children. She identified the period just before deployment as the most stressful for children. Children who experienced a peacekeeping deployment had some behavioral problems that decreased over time, whereas the problematic behavior of war-separated children did not improve over time. Furthermore, although total *number* of deployments did not increase anxious and depressive symptoms in children, the *length* of deployment had the opposite effect (Jensen et al., 1989).

As the number of mothers in the armed forces increases, research concerning the effects of mother absence has also increased. The finding that children's psychosocial functioning is equally affected, regardless of whether they are separated from mothers or fathers (Applewhite & Mays, 1996), suggests that much of the literature on father absence may be relevant for mother absence as well. As in the research on father absence, children of deployed Navy mothers have been found to have higher levels of internalizing behaviors (e.g., fearfulness and sadness) than do their civilian counterparts (Kelley et al., 2001). These children also exhibited higher rates of externalizing behaviors (including aggressiveness and noncompliance). Pierce, Vinokur, and Buck (1998) found that children separated from their mothers during war deployments often experienced adjustment problems; these problems worsened with the degree of disruption in a child's life and the mother's failure to provide stable child care during the deployment. These effects disappeared 2 years later, however.

Additional Stressors for Military Families

Geographic Mobility

A common feature of military family life is geographic mobility. This mobility may occur within the continental United States, as well as across the world in such places as Alaska, Hawaii, Germany, and Japan. Military families may move as often as once every 2 to 3 years. This can be difficult for military children, who may repeatedly experience the loss of friends, change of schools, and separation from extended family members.

The effect of geographic mobility on children is a further area of study in the military family literature. Generally, length of residence is associated with better peer relations and less loneliness for children (Kelley, Finkel, & Ashby, 2003). Family relationships in general and relationships with mothers in particular play an important role in mediating the effects of relocation (Kelley et al., 2003; Pittman & Bowen, 1994). The quality of parent–child relations is the most important factor in children's adjustment (Pittman & Bowen, 1994). Positive relationships with mothers are related to a reduction in feelings of loneliness and fears of negative evaluation. Depression in mothers is associated with anxious and depressed behaviors in children, who also display more aggression and noncompliance (Kelley et al., 2003).

Race/Ethnicity and Family Composition

Military families may include all races and ethnicities, and sometimes they are mixed in their composition. For example, it is not unusual to have a family in treatment in which the father is African American, the mother is German with biological children from an earlier relationship, and the children of the present relationship are of mixed African American and German heritage. Foreign-born military spouses may have limited English skills, further complicating their adjustment and that of their children. Cultural and blended-family issues can be major factors in practice with these families and should be initially acknowledged.

Other Issues

Further matters to consider in working with military families include sexual harassment, limited financial resources, and single parenthood. Female military personnel may experience sexual abuse/harassment on the job, and this can have an impact on their children. This sexual harassment may compound past sexual abuse, awakening this issue within a family. Junior enlisted families also often do not have the financial resources to buffer the stressors they experience. For instance, they may not have reliable transportation, and many military installations are located in rural areas with no public transportation. On-post housing may be in short supply, forcing these families into substandard off-post housing. Finally, increasing numbers of military personnel are single parents, and the effects of this on their children must be considered, especially in combination with the other issues mentioned here.

Effects of the Deployment Cycle on the Family System

In 2006, the average length of deployment associated with military service in the U.S. Army or the U.S. Marines in Iraq and Afghanistan ranged from 12 to 15 months. This represents an increase over previous peacekeeping missions of 6 months to the Balkans and Kuwait during the late 1990s. From a family systems perspective, the deployment cycle represents a change and a challenger to the structural integrity of a family system.

After the deployed service member departs, the family system must adjust to this loss. As part of this adjustment process, family members often experience a variety of physical disruptions (e.g., lack of sleep, loss of appetite, anxiety, malaise) and emotional maladies (e.g., sadness, irritability, dysphoria) during the first few months of a long-term deployment. Often during this time, families will seek assistance for any number of symptoms associated with the strain of deployment. As the deployment lengthens, the family tends to adjust to the stressors and strains associated with functioning without the service member, eventually achieving a new homeostasis. This adjustment may be achieved with professional assistance and/or through the family's extrasystemic involvements, such as religious affiliation, military unit support, or the school system.

Later, the prospective return of the service member creates a new set of strains as the family prepares for the upcoming changes in its functioning. The waiting spouse (traditionally the wife, but increasingly often the husband) may experience ambivalence in balancing the anticipated loss of autonomy with the joy of reconstituting the family. Children may respond to the return of the service member with many different emotions, depending on their developmental stage and any existing emotional difficulties. The family members often experience a "honeymoon phase" after the return of the service member, varying in length and intensity; yet after a lengthy absence, the return often presents the family system with a new set of challenges, as the family and the service member attempt to readjust and realign their roles within the system.

When the service member has experienced physical or emotional trauma associated with combat exposure (wounds, PTSD, combat stress, etc.), this trauma may be experienced by the family system in a reactive manner (Figley, 1998a). The spouse experiences role strain as he or she takes on the burden of caring for the ailing service member, potentially reducing her (or his) caregiving capacity for any children within the household. This strain increases the children's anxiety, creating new symptoms or exacerbating existing symptoms from previously unresolved stresses. This set of circumstance causes further role strain in the cycle, due to increased demands from various family members. Over the course of multiple deployments, stresses may pile up and remain unresolved, thereby creating a backlog of difficulties within the system (McCubbin, Thompson, & McCubbin, 2001).

Secondary Trauma: Implications for Children and Families

Many soldiers returning from Afghanistan and Iraq have trauma symptoms related to their war experiences, as noted earlier. Soldiers with PTSD are often withdrawn and avoidant; may experience flashbacks, exaggerated startle responses, and even fugue states; and may also be prone to intermittent rage. These symptoms can have a profound effect upon other family members. Spouses and children in families of military personnel with PTSD are susceptible to developing secondary traumatic stress symptoms.

The origins of secondary trauma theory were described in reports on clinical practice with Holocaust survivors and their families (see Danieli, 1998) in the late 1960s. A seeming conspiracy of silence prevented Holocaust survivors from integrating their traumatic experiences, due to the failure of others (including therapists) to listen and believe their traumatic accounts. Danieli found that the children of these survivors seemed to have absorbed their parents' Holocaust experiences and displayed psychological symptoms that appeared to be connected with those experiences. Secondary trauma theory further evolved from the reports dealing with military families. Rosenheck and Nathan's (1985) clinical experience with children of Vietnam veterans led them to coin the term "secondary traumatization," which they defined as "the relationship between the fathers' war experiences and subsequent stress disorder and their children's problems" (p. 538).

Charles Figley (1998b) has developed and defined many of the concepts related to the definition of secondary trauma. According to Figley, such trauma includes "the experience of tension and distress directly related to the demands of living with and caring for displays of the symptoms of post-traumatic stress disorder." as well as "the natural and consequent behaviors and emotions resulting from knowledge about a stressful event experienced by a significant other" (p. 7). Over time, secondary traumatic stress can lead to emotional exhaustion and burnout. In a family, this burnout results in "the breakdown of the family members' collective commitment to each other and a refusal to work together in harmony as a function of some crisis or traumatic event or series of crises of crises or events that leave members emotionally exhausted and disillusioned" (Figley, 1998, p. 7).

Secondary trauma symptoms have been considered to be similar to but less intense than PTSD symptoms; they include avoidance, intrusion, and arousal (Motta, Joseph, Rose, Suozzi, & Leiderman, 1997). Figley (1998a) suggests that these symptoms include "visual images (e.g. flashbacks), sleeping problems, depression, and other symptoms that are a direct result of visualizing the victim's traumatic experiences, exposure to the symptoms of the victim, or both" (p. 20). Indeed, children of parents with PTSD have been found to have significantly more somatic complaints, social problems, attention problems, and aggression than the children of parents with substance abuse have (Dan, 1996).

Due to the high levels of trauma experienced by military personnel in Afghanistan and Iraq, and the resultant levels of PTSD, therapists will be called upon to treat members of these families. Although the military is now making every effort to identify personnel with PTSD, many members of the military continue to feel that a stigma is attached to mental health treatment. Often family members of traumatized military personnel take the initiative in seeking treatment. Children in these families present in therapy with symptoms that mimic PTSD, as well as with anxiety and depressive symptoms. These symptoms are directly related to the trauma symptoms of their parents. Play therapy is a useful approach in the treatment of children within these traumatized families.

SYSTEMIC PLAY THERAPY WITH CHILDREN IN MILITARY FAMILIES

The systemic approach to play therapy views children and their families as members of a dynamic, ever-developing system, capable of constant adjustment and adaptation within their larger social contexts. The following three goals apply to play therapy with a child of a military family who is in crisis:

- Reduce the child's symptoms.
- Include the parent(s) in the child's therapy, in order to help her, him, or them understand the child's difficulties and to encourage parental interaction with the child.
- Employ psychoeducational interventions to assist the child with life changes related to the parent's deployment.

The therapist begins by seeking to engage the child (and family) in a therapeutic setting and a secure environment in order to relieve the child's symptoms. Because these are often related to the military parent's stressful service-related experiences, it is important from a systemic perspective that this parent be present if at all possible (and certainly that the other parent be present). Parents are also included in sessions to create positive understanding of the therapeutic interventions and to model play as an interactional component of the parent–child relationship. In short, not only are parents crucial to the assessment process, but they should remain in as many sessions as are necessary to complete the planned course of treatment. Finally, play is utilized in a proactive way to help reduce anxiety over anticipated or actual life events and changes, such as relocation, deployment, or reunification. This multifocal model, adapted from Webb's tripartite approach (see Webb, 1999 and Chapter 1, this volume) provides a framework for understanding the impact of a crisis situation in interaction with personal and familial factors influencing the crisis response, as well as the extrasystemic support factors determining the nature of the familial (mal)adaptations. Ultimately, the use of play as a therapeutic tool allows for a corrective emotional experience, bringing the child's daily functioning into synchrony with his or her appropriate developmental age and with systemic expectations.

A child's cognitive, emotional, and social developmental stage influences the child's perception about his or her role within the family system. The play therapist takes account of the child's developmental stage and responds to the child according to a particular theoretical and practice framework. O'Connor (1991) presents several different models of play therapy, but space does not permit us to discuss all of these here. We use an approach that attempts to integrate family systems methods with crisis intervention play therapy, while always relying on developmental factors to guide the treatment. We believe that this systemic, contextual model is appropriate for children in military families. The developmental stage of the child determines the particular methods of play used, with family dynamics and larger systemic factors providing the context for assessing the symptoms, treating the problems, and working on relapse prevention.

Play Therapy with Preschool Children (0–5 Years)

The approach to play therapy with preschoolers takes two distinctive forms, corresponding to the two phases of the preschool age range: 0–2 years and 2–5 years.

Children in the 0–2 age range are said to be in Piaget's "sensorimotor" phase of cognitive development, where learning is largely experiential and the children are beginning to develop trust in their caregivers (Thomas, 2000). The development of an attachment relationship also occurs during this period (Bowlby, 1969). A child may become anxious during this developmental stage because of a separation due to deployment or the return of a service member who deployed when (or even before) the child was born. In either case, the child's anxiety is the by-product of a disruption in the family environment caused by the deployment.

The goals of play therapy at this phase are (1) to reduce the child's anxiety by building another trusting relationship, and (2) to restore the balance in the caregiving relationship between the child and the parent(s). The therapist also assesses for parental dysfunction. Therapy at this stage should involve mostly experiential and nonverbal play, which includes tactile stimulation to engage fine motor skills and stimulate sensory input. The parent(s) should be encouraged to participate in playing with the child as a way to enhance the bonding relationship. Simple puzzles with large pieces, and soft overstuffed animals, are good for working with children under the age of 2. Wood or plastic building blocks with numbers and letters are also important for helping improve spatial abilities and object identification. These blocks should be oversized for easy grasping and manipulation. All objects used in play should be easily washable, should be large enough to prevent choking, and should represent the basic primary colors (see Webb, 1999 and Chapter 3, this volume).

Children who range in age from 2 to 5 are said to be in Piaget's "preoperational" phase of cognitive development (Thomas, 2000). Learning during this stage includes labeling of familiar items in their world. The development of object constancy permits the understanding of "sameness" from one situation to another (i.e., the principle of conservation). Children also begin to act in a more autonomous manner as they continue to achieve mastery over certain basic tasks, such as achieving bowel control and learning shapes and colors (Erikson, 1963). They become more verbal as well, and are capable of dynamic interaction with an ever-increasing array of caregivers within a growing number of environmental contexts. In particular, they acquire a limited affective vocabulary consisting of the basic emotions of happiness, sadness, anger, and fear, as well as the ability to process the emotional experiences of others. Sex role identification occurs toward the end of this stage, as a part of the children's increased sense of self-awareness. At this age, children may act out frustrations that they experience in their interpersonal relationships with tantrums lasting as long as 20 to 30 minutes, but these usually diminish with increasing age. Many preschool programs begin to enroll children at the age of 3, thereby widening the opportunity for peer interactions.

Therapy during this period should involve the use of play materials that permit a child to create scenarios, such as dolls, dollhouses, action figures, and various puppets. In addition, crayons, finger paints, and Play-Doh modeling compound allow preschoolers to express their creativity while also relieving their anxieties in the process of play therapy (Webb, 1999, and Chapter 3, this volume).

Play Therapy with School-Age Children (6–11 years)

Children who range in age from 6 to 11 are said to be in Piaget's "concrete operational phase" of cognitive development (Thomas, 2000). They are able to conserve, classify, and serialize by the time they are about 6 years old. Their enhanced cognitive processes make their perceptions more consistent with reality, and enable them to retrieve information and to remember. Particularly important to a child during this phase is the sense of "moral reciprocity" (i.e., what's fair for one is fair for all). Children at this age begin to compare themselves with their peers, and to experience guilt when they believe they are to blame for something (Erikson, 1963).

Children from 6 to 11 years of age are particularly susceptible to problems associated with relocation. These include school changes; lack of continuity between school systems (if previous problems have been identified, such as attention-deficit/hyperactivity disorder [ADHD], learning disabilities, etc.); and difficulties with the fully integrated Department of Defense K–12 school systems on major military posts (Hardaway, 2004). These children are also at higher risk for depression and anxiety stemming from the lengthy separation caused by deployments and the potential problems of reunification upon the service member's return. They may experience a reemergence of bedwetting and other symptoms that are generally typical of younger children.

Play therapy with school-age children may involve thematic play and role playing, which helps engage the child's developing imagination. The use of sandplay in therapy with school-age children in military families permits them to imitate the experience of their service member parents who are deployed to the desert. Dollhouses are still important at this stage, as these permit the children to act out play themes that may represent disturbing family issues (Webb, 1999, and Chapter 3, this volume). Art therapy using washable color pens and markers, along with the use of sculpting clay and decoupage, can enable a child to draw or create scenes of emotional content.

PHASES OF PLAY THERAPY FOR MILITARY CHILDREN

A number of factors determine the approach to play therapy for children of families within the military. The cycle of departures, separations, and returns of service members due to deployments creates a difficult set of circumstances for all members within the family (Daley, 1999; Hardaway, 2004); these issues are compounded if the service member returns from duty physically injured or psychologically traumatized by the experience. Furthermore, the adjustment upon return may be disrupted by problems that may have transpired at home while the service member was deployed (Figley, 1998a). Taking a multifocal systemic view of the child and the family is thus imperative for the clinician beginning a therapeutic relationship with the child.

Assessment

The first phase of treatment involves *assessing* the child for symptoms and the family for systemic problems that may be associated with the child's current problems. Sleep and appetite disturbances, bad dreams, negativistic fantasies, crying spells, irritability (related to anxiety), agitation, fearfulness, reemergence of bedwetting, and hypersensitivity to interaction are common among children across various developmental stages (O'Connor, 1991). Steinberg (1998) has argued that such symptoms may stem from a child's experience of secondary traumatic stress. According to Steinberg (1998), several risk factors for secondary traumatic stress should be considered; these include the child's gender and birth order (an oldest) female child may be particularly susceptible), the existence of previous symptomatology, and a lack of familial social integration (i.e., lack of religious or other community involvement). If the child has preexisting emotional or behavioral problems, such as symptoms of ADHD or oppositional defiant disorder, these may be compounded by the stress associated with the deployment cycle and may actually mask deeper symptoms of depression or anxiety, which should be assessed thoroughly and carefully.

Multigenerational genograms (McGoldrick & Gerson, 1985) have been used to assess families upon entry into family therapy, and these are especially important in teasing out the extent to which systemic difficulties may be influencing a child's symptoms. Initial treatment planning should be completed by the end of this assessment period. This phase of treatment usually lasts one to three sessions, and the introduction of play within the family sessions is a part of this phase of treatment.

Joining

The second phase of treatment involves *joining* with the child and the family. This phase builds upon the trust and rapport that have been established in the assessment phase. This process usually lasts between three and five sessions, as the child and family members grow more comfortable with the therapist and the therapeutic process. If families have reservations about play therapy and/or trepidation about its effectiveness, the therapist needs to reduce their resistance to play's inclusion in the ongoing therapy. It is important to build the therapeutic alliance before the next phase of treatment begins (Sori, 2006). The end of this phase involves an agreement about the essence of the problem (or problems) and all of its systemic aspects.

Maintenance

The next phase of therapy involves the *maintenance* of the already existing therapeutic relationship. This is the longest stage of treatment, lasting from 5 to 15 sessions; it often involves engaging in play therapy with the child, seeing the entire family for family therapy, and combining the two approaches in single sessions from time to time. It is often prudent to involve a sibling in the play therapy and/or family therapy sessions. Continuing to cultivate the deepening therapeutic relationship is most important; however, problem solving and the use of directives for changing behaviors among members of the system are also important. Fostering problem-solving behavior improves coping and helps to buffer the family members from ongoing stressors in their daily lives, while therapeutic directives and first-order feedback are used to bring about change in the system (Berg-Cross, 2000). One of the primary expectations of this approach is that "triangulation" will occur between the family and the therapist, and that the therapist can use this dynamic as a tool for facilitating change within the family system.

Closure

The final phase of therapy involves *closure* with the child and the family in the process of terminating the case. During this final phase of the relationship, it is important to check progress, begin the end of therapy with appropriate processes, and make sure that relapse prevention procedures have been put into place. This phase of therapy usually lasts from two to three sessions. The therapist must use intuition and sensitivity to the family's circumstances in determining when the time is right for ending a particular course of treatment. Central to this approach is the understanding that the therapeutic relationship means different things to the various people involved in the therapeutic process. In essence, therapy may never be "over," and clients may return at different stages of the family life cycle as problems reemerge. It is not uncommon in a practice with military families for these families to return even after they have moved away from one installation to another. With this approach, it is always best to maintain an "open door" policy.

CASE EXAMPLES

Alisha, Age 2¾

Background on Referral

My agency received a call inquiring if we saw children as young as 2. I (Joseph Herzog, the therapist in this case) assured the office manager that indeed we could see the child. I spoke with the child's mother before the first session. She reported that her husband, an Army sergeant, was away from home on an extended peacekeeping mission, and that she was concerned that her 33-month-old daughter, Alisha, was very depressed. She stated that Alisha often seemed sad, cried easily, and frequently awoke at night asking for her father. She also said that prior to the separation, neither she nor her husband had had any concerns about their daughter's physical or emotional development. Based on my previous experience with military families experiencing these kinds of difficult and prolonged separations, my concern going into this session with Alisha and her mother was that Alisha might be reflecting her mother's upset as well as her own.

Parent–Child Play Therapy Session

When Alisha and her mother arrived for their appointment, I began by explaining my position in the agency, my educational background, and the limits of confidentiality. I then gathered information about Alisha and her family. They had been living in this community for about a year, and this was their second Army duty station. Alisha was the couple's only child. Alisha's father had enlisted in the Army and intended to make the military a career. Prior to this deployment, Alisha's father had been away from home for only one brief training mission. This was the first and only lengthy absence for either Alisha or her mother. The child had been told that her father was away at work and wouldn't be coming home for a while. For the past 2 months, while on this peacekeeping mission, he had been maintaining contact with his wife and daughter through regular letters and occasional phone calls.

My interview with Alisha and her mother took place in a playroom with a variety of toys, and Alisha was immediately attracted to a table with large Legos blocks. After gathering the background information from Alisha's mother, I got down on the floor with Alisha; she readily accepted my presence and my participation in play with the blocks. A few minutes into the play, I built an airplane from the Legos and said, "Is this an airplane like the one your daddy flew away on?" (I knew from my earlier conversation with her mother that Alisha had been brought to the airport to see her father off at the beginning of the deployment.)

Alisha immediately stopped her play and put her head down on the table. A moment later, she quickly withdrew from the play table to the couch where her mother was sitting, and crawled up and onto her mother's lap. It was clear that she was no longer interested in play. It was also clear that my statement was just as upsetting for the mother (there were tears in her eyes as well), and that Alisha was holding on to her mother in what was seemingly an experience of mutual comfort. I said I could see that they both were sad, and that they must miss their father/husband.

At this moment I realized that my original speculation concerning Alsiha's symptoms was probably correct. I also realized now that Alisha was responding to her mother's sadness as well and that the mother's own sadness might be making it difficult for her to provide the type of parenting needed at this stressful time in this young child's life.

Comments on the Session, and Description of Further Inventions

When I constructed the airplane, I was initiating a directive play approach because I wanted to assess Alisha's reaction to the toy plane. Some therapists might consider that my actions were upsetting to the child and caused her to withdraw from me. I took the risk because I knew that the mother was present and available to comfort the child.

Interventions in this case focused on providing guidance and supportive counseling for Alisha's mother, to meet her own emotional needs associated with her husband's absence. Pointing out to her how her daughter was responding to her obvious sadness and worry, rather than being able to use her as a source of comfort and support, allowed the mother to see the importance of dealing with her own emotional needs first. In addition to a period of brief supportive intervention, I was able to encourage her to get involved in a support group for unit spouses available on the military installation. She also joined a local church, where she found a number of other young mothers who were very supportive. At my suggestion, Alisha's father recorded himself reading one of Alisha's favorite bedtime stories, and he sent home pictures of himself overseas. He also made more frequent phone calls that included time for Alisha to hear her dad's voice. Over the course of the separation, Alisha responded to her mother's renewed resilience and continued her normal development.

The key therapeutic interventions in this case were acknowledging Alisha's and her mother's depressive symptoms, working with Alisha's mother in brief treatment to express and better understand her own feelings, and connecting Alisha's mother with military and community support systems. I also offered the mother some useful suggestions for helping her daughter and husband maintain their relationship during this absence.

Tom, Age 7

Family Information

The identified client was Tom, a 7-year-old European American male. His family consisted of his biological father, who was on active duty in the military; his stepmother; a 5-year-old biological sister; and a 1-year-old half-brother. In addition, Tom's stepmother was pregnant. The client had no contact with his biological mother, from whom he had been removed at age 4 due to physical and possibly sexual abuse. The client's father was fairly new to the Army and had recently returned from a tour in Iraq, which involved combat. There were indications that the client's father had preexisting mental health issues, but he was also displaying posttraumatic symptoms. Tom's family had relocated from the Midwest to a large Southeastern post. They were geographically removed from the physical support of their extended family and had few local social supports in place.

Presenting Problem

Tom presented with a history of violent behaviors directed both within and outside of the family, as well as suicidal ideation and threats. Tom had had multiple psychiatric hospitalizations and was in a long-term residential facility at the time of the referral.

First Contact with Child and Family

A therapist in the long-term inpatient facility contacted me (Joseph Herzog, the therapist in this case) about Tom. We arranged to conduct family therapy sessions via the telephone, with the residential therapist leading sessions from her office with Tom, while I cofacilitated with Tom's father, stepmother, and occasionally his siblings at my office. These sessions were a combination of parent education, play therapy, and logistical planning. They were conducted biweekly over the course of a few months. After Tom was released from residential care, the family scheduled an appointment at my office.

First Play Therapy Session

Tom's parents brought Tom to the session. They reported that Tom, although he was testing some boundaries, had demonstrated acceptable behavior since he had been home. They stayed in the waiting room while Tom and I went into the playroom.

Content of Session	*Rationale/Analysis*
Joseph Herzog: See what we're going to do? Look at that right there; we're going to videotape our session today, OK? Think you might want to watch it some time? Come on in here.	I am introducing the idea of taping the session, showing him the recording devices and camera, and letting him know that we are preserving this session for future reference.
Tom: What are we doing today?	
JH: Look what we're going to do today. I'd like for you to draw a picture. You get to draw on this big piece of paper right here. How about that? Can you draw a picture of *yourself*? T: I don't know how to draw.	I am setting the agenda for the session. He's telling me he's not so sure about this agenda. Tom may have found drawing a picture of himself too threatening. An alternative would have been for Tom to draw a picture of a person. A typical response when a child doesn't want to draw.
JH: Can you draw a picture of your family doing something? T: No.	I consulted with a peer on an approach for the first session. We decided to have Tom draw a picture of himself to

	gain insight into his image of himself, and to have him draw a picture of his family engaging in an activity to determine his view of his family. As is occasionally the case with carefully scripted sessions, this one goes flying out the window with his refusal. I have a moment of panic as I worry that this case is going to end terribly, with the client escalating in a power struggle with me and going back into residential care.
JH: Then we could play with some toys and some sand. T: Where?	I attend to his refusal through negotiating the session. Some might see this as bribery; others might perceive that I am being flexible.
JH: I've got a whole bag of toys right here. We can play with these after we do some drawing. How about that?	I think he is testing limits. I continue to worry about a power struggle with Tom. I know that it will be unwise to lock horns with him.
T: Can I draw whatever I want?	
JH: Well, you can draw three pictures: you can draw a picture of yourself, a picture of your family doing something, and then a picture of whatever you want. How about that?	Further negotiation. I am holding firm to my original request.
T: But how about I only draw one picture?	He doesn't want to draw people.
JH: You can draw on one piece of paper if you want. Do you think you could draw on this big piece of paper right here? T: Yeah.	I try enticing him with drawing on the flip chart. He engages in this idea.
JH: OK, let's see that. I like your shirt. T: Thanks. JH: That's cool. Where did you get that? T: My dad. JH: Your dad gave that to you? That's really cool; you've got helicopters and tanks. T: Yeah. Do you know how some people do this?	I notice he is wearing a T-shirt with a military theme. I comment on it, bringing a connection to his father. I am trying to enhance this relationship, as it is crucial to Tom's transition back into this family.

JH: How do they do that?	
T: They draw like that.	
JH: Yeah?	
T: And then they just try making it very pink.	
JH: Yeah? You got a haircut, didn't you?	Another connection with his father.
T: Yeah.	
JH: How do you like it?	
T: It's pretty good.	
JH: Yeah?	
T: Where's the purple?	
JH: I see a purple right there.	
T: Green purple.	
JH: Green purple.	
T: Yellow and black.	
JH: Yellow and black. That purple looks better than the other purple, doesn't it?	
T: Yeah, it doesn't write very well. Yellow. My dad's at work.	He is clearly thinking about his father as he is drawing the picture. He appears to be picking up military lingo and has some understanding of some of the activities soldiers engage in.
JH: What's he doing?	
T: I think he's talking. I think he's doing something. I don't know what he's doing, like PT or something.	"PT" refers to physical training, which typically occurs every morning before a soldiers reports for duty.
JH: Oh, he's doing PT. Do you do PT?	
T: No. PT is what soldiers do.	
JH: What's that mean?	
T: It's just when they work out.	
JH: Yeah? I wonder if we have any other markers. Crayons.	He is drawing a picture of a heart with a mixture of colors in it. He wants to include every color available.
T: I'm being crazy and drawing.	Why does he use the word "crazy" to describe himself?
JH: Yeah, you're being crazy and drawing.	
T: Pretty fun to do it.	

JH: It's fun to draw on a big piece of paper, isn't it?	
T: Yeah. This looks like black.	
JH: Yeah.	
T: What colors aren't used?	
JH: I don't know.	
T: Orange and pink.	
JH: True. That looks like that tip doesn't work.	
T: Pink, but this one's getting really gray.	
JH: I wonder if there's another pink one.	
T: Oh, here's one.	
JH: OK.	
T: Doesn't that look good? JH: That does look good.	He is finished drawing and is quite proud of it and his ability. He wants my approval.
T: It looks like a rainbow.	I am encouraged by his metaphor.
JH: It is a rainbow; it's got all the colors in it, doesn't it?	
T: Yeah.	
JH: Are you all done with your picture? Tell me about it. T: It's just a heart with a bunch of colors. JH: Oh, OK. Is that what you think of when you think of your family or think of yourself?	Before offering my interpretation, I check to see if it is correct. I have learned that children often have completely different ideas about their art and play, and are bewildered by my misinterpretations. It is always better to let them tell about their drawings.
T: Yeah.	Quite a positive association.

Further Treatment and Comments

This session concluded with a period of sandplay. The second session consisted entirely of sandplay. Tom appeared to be engaging in the therapeutic process and was beginning to express his feelings about his past abuse and his current family situation. His biological father and stepmother continued to attend his therapy sessions.

Tom's crisis was one of reintegration. This is a common type of crisis in military families, as family members are often separated from one another for extended periods of time. This crisis was somewhat unusual, however, in that it was the child reintegrating into the family instead of the redeploying parent. Another aspect of reintegration is that it has to occur not just within the family, but also with other community institutions. The school that Tom attended did not have a self-contained classroom for children with emotional and behavioral issues. Instead, Tom followed a teacher from classroom to classroom. Sadly, I got a call one day that Tom had acted out in school with his behavior escalating. His parents were called to pick him up from school. At home he began to engage in self-harming behavior, threatening suicide once again. He was again sent to an inpatient facility.

This child who had so adeptly expressed his feelings to me through his artwork could not cope successfully in the community. I had anticipated problems when Tom's stepmother gave birth and when his biological father redeployed, and I was working with his parents in anticipation of these events. I failed to consider possible problems in the community, however. I believe that Tom was overwhelmed by the lack of structure in his school situation. I continue to work with Tom's family for his eventual return, and I will consult with the school regarding an appropriate placement for him.

CONCLUSION

This chapter has emphasized the opportunities and challenges of play therapy with military children and families. We have illustrated the importance of understanding families within the context of an inflexible institution like the U.S. military that creates its own stressors, such as relocation, deployment, and reunification. These stressors affect not only the deployed parent, but his or her spouse and children, and must be considered in any therapeutic interaction using this systems-based approach.

As we continue into the 21st century, the world has become increasingly complex and dangerous. Children whose parents are repeatedly placed in harm's way through military service must live not only with the reality of parental separation, but also with the possibility of parental injury or death. Practitioners must be adept at using a variety of methods and approaches to helping these families. We hope that this systems-based model of play therapy will provide those who utilize it with the tools necessary to help improve well-being and quality of life for those military families they treat.

Study Questions

1. The therapist used a directive role in the case of Alisha. What are the pros and cons of confronting a child with reminders of a traumatic memory (such as the airplane that took her father away)? How else could the therapist have intervened with Alisha?
2. The therapist was firm in having Tom draw a picture of his family. What

are the risks of doing so, and how else could the therapist have proceeded at that point?

Role-Play Exercise

1. Three siblings have been referred to you after their father has been hit by an improvised explosive device. He suffered severe injuries and has been flown to Germany for surgery. This family has recently relocated to a new post, with no extended family close by, and limited social support. The children present with trauma symptoms. The oldest child is a 7-year-old girl (the mother's daughter by a previous marriage); a 6-year-old boy is the middle child, and he has a 3-year-old brother. The children's mother informs you before the first session that she is considering leaving the children with her parents, who live several hundred miles away, and flying to Germany to be with her husband. If you were the therapist, how would you structure the session? Role-play an initial meeting with all family members present, and then a second meeting with the mother alone.

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Part III

SCHOOL-BASED CRISIS INTERVENTION

Chapter 12

New Approaches to Preventing Peer Abuse among Children

Elizabeth K. Englander
Christine Lawson

In the 2004–2005 school year, there were 39 school deaths in the United States, 24 of which were shootings (National School Safety and Security Services, 2005). The most common reason students bring weapons to school is protection against bullies (National Youth Violence Prevention Resource Center, 2002). We now know that the school shooters of the 1990s often reported being the chronic victims of bullies (Cohn & Canter, 2003). In the 1990s, multiple-victim shootings in suburban and rural school districts caused enormous alarm and dismay, and although most attacks in more recent years have been averted, vigilance and fear remain high (Englander, 2001).

The specific problems posed by bullying among children include (1) risk of physical injury from assault; (2) elevated risk of depression and other mental health problems in both victims and bystanders; (3) increased risk that bullies will ultimately have contact with the criminal justice system; and (4) risk of extreme violence in victims of bullying, including both suicidal and homicidal behaviors.

Nationwide statistics suggest that somewhere between one in six and one in four students are frequently bullied at school (Nansel et al., 2001). Hurtful and direct bullying begins in elementary school, peaks in middle school, and is still present but somewhat less frequent during high school (Banks, 1997). One study of Massachusetts schools found that most children who were bullied in the state were victimized for 6 months or longer (Mullin-Rindler, 2003). The U.S. Department of Education (2002) found that bullying increased 5% between 1999 and 2001, and the National Education Association (NEA, 2003) has suggested that bullying is a serious problem in U.S. schools.

WHAT IS BULLYING?

For the purposes of this discussion, "bullying" refers to physical and/or psychological abuse perpetuated by a more powerful child upon a less powerful one, with the intent to harm or dominate. Typically, bullying is repetitive, is intentional, and involves an imbalance of power (Olweus, 1991). Bullies enjoy social power and therefore seek out situations where they can dominate others. Bullying can be either direct, such as physical or verbal aggression, or indirect, such as insults, threats, name calling, spreading rumors, or encouraging exclusion from a peer group (Olweus, 1993).

People often confuse "conflict" with "bullying." Conflict is an inevitable part of life and involves a disagreement between two people with relatively equivalent social power. On the other hand, bullying involves an attempt to control and abuse. It is important to differentiate the two, because mediation, which can be very effective in a conflict situation, can actually be harmful and potentially dangerous in a bullying situation (Englander, 2005).

According to research conducted by Olweus (1993), bullying has become significantly more serious since the 1960s. Unfortunately, adults often consider bullying an inevitable and even normal part of childhood. As a result of this attitude, adults sometimes fail to intervene, resulting in victims feeling powerless and hopeless in a torturous situation (Davis with Davis, 2005). A shift in the social status of bullies may also be contributing to the growth of this behavior. Whereas a generation ago bullies were socially stigmatized, today children may admire or even emulate these aggressors, rendering them much more socially successful. The overwhelmingly pervasive nature of positive aggressive images in media and the resulting desensitization may account for the tendency of children today to see bullies as socially powerful and to dismiss (or fail to see as negative) the aggressive nature of their power. This social shift contributes to a "copycat" response of bullying behavior by many children and adolescents in an attempt to gain social status (Englander, 2006).

As part of the move toward a digital society, bullying has not only been influenced by, but also influences, the world of cyberspace. Technology has facilitated massive dissemination of hurtful messages, resulting in an epidemic of bullying known as "cyberbullying." At this writing, cyberbullying occurs primarily through webpages, online social networking websites, and instant messaging via the Internet and cell phones. (It is possible that by publication time, new technologies may have spurred new types of cyberbullying.) The unique nature of cyberbullying is that it can be done anonymously and thereby permits children who might not otherwise participate in bullying behavior to engage in it. A characteristic that makes cyberbullying so insidious is that derogatory statements, threats, and humiliating pictures or videos of a person can instantaneously be sent to hundreds of viewers with the click of a button. This can exacerbate the feelings of vulnerability that adolescents already experience due to their normal developmental stage; many if not most teenagers feel constantly watched ("on stage," as it were) in front of an "imaginary audience." The days when bullying was limited to the schoolyard, classroom, or hallway are over. This presents a unique challenge to our society as we grapple with how to deal with this increasingly frequent form of bullying (Englander, 2006).

IMPLICATIONS OF BULLYING

The problems associated with bullying are long-lasting for both the bully and the victim. A longitudinal study by Fox, Elliott, Kerlikowske, Newman, and Christeson (2003) followed boys who were classified as bullies between the sixth and ninth grades into their adulthood. Nearly 60% of these boys were convicted of at least one crime by the age of 24, and 40% of them had three or more convictions by the age of 24. This study suggests that a child with a cognitive style that contributes to the aggressive behavior associated with bullying is at high risk of ending up in the criminal justice system as an adult. Another study, by Garbarino and deLara (2002), found that youth who bully become more violent over time. This body of research suggests that bullies should not be seen as innocuous, because without intervention they may become unpleasant and expensive problems for society later in life.

The problems associated with the victim of bullying are serious as well. Children who are bullied are five times more likely to suffer from depression. Boys who are bullied are four times more likely to be suicidal, and girls who are bullied are eight times more likely to be suicidal (Fox et al., 2003). According to the NEA (2003), an estimated 160,000 children skip school each day because of intimidation by their peers. Children and adults who are bystanders are also seriously affected. Mullin-Rindler's (2003) research in Massachusetts found that 14% of children reported chronic fears of being bullied in the future. Children who see bullying occur may suffer in a school climate of general fear and disrespect. There can be little doubt that such a school climate, where violence and aggression are rewarded instead of minimized, interferes with learning (NEA, 2003).

DIFFERENT TYPES OF BULLIES

Many theoreticians have offered typologies of bullies. The following typology has been developed (Englander, 2006) in response to the advent of cyberbullying and the resulting comparisons that now occur between traditional schoolyard bullying and cyberbullying. One might assume that a child who would be a cyberbully would also be a bully face to face, and this is sometimes the case; however, other cyberbullies never bully in person. These "only-cyberbullies" may be children who are well behaved, generally popular, and kind, and/or who show a significant level of investment in school and academia, as well as in the approval of adults.

The following discussion distinguishes five types of bullies:

1. *Traditional schoolyard bullies*. The motivation of traditional schoolyard bullies is to dominate their victims, increase their own social status, and instill fear in potential victims. Their *modus operandi* is to abuse their victims, either physically or psychologically/verbally. As a group, they tend to have high self-esteem and a marked tendency to perceive themselves as under attack in a hostile environment (Staub, 1999). Their academic achievement may be moderate to poor, and aggression is their preferred tool for domination. They rely on peer support or lack of intervention in order to continue their activities. Limit setting is the adult response that operates best to reduce this type of bullying behavior (Olweus, 1993).

2. *Eggers*. "Eggers" (referred to by Olweus [1993] as "henchmen" or "followers") are so called because their main function is to egg on bullies. These children are a primary support system for traditional schoolyard bullies. Eggers often have poor self-esteem and poor social skills. They befriend and assist bullies because they fear being victimized, and because by doing so they gain high-status, socially powerful friends. Unlike bullies, they do not see their own bullying behaviors as a justified response to a hostile world; they accurately perceive that their behaviors are harmful and unacceptable, but they tend to minimize their own involvement or minimize the impact of their own behaviors.

3. *All-around bullies*. "All-around bullies" are schoolyard bullies who are widening their bullying activities into the electronic realm (i.e., cyberbullying). Their motivation and *modus operandi* are the same as those of traditional schoolyard bullies; they simply regard the electronic realm as a new area of opportunity to continue their abusive activities.

4. *Only-cyberbullies*. As noted above, "only-cyberbullies" are children who would not engage in schoolyard bullying, but do engage in cyberbullying because they have certain beliefs or attitudes that support cyberbullying specifically. For example, cyberbullies who would not bully in person may believe that they can engage in cyberbullying without any risk of negative consequences to themselves, because adults are seen as simply not being part of the virtual world. Although fear of punishment may prevent them from bullying face to face, they may consider cyberbullying a powerful behavior that carries no risk of punishment. Alternatively, some children who would not otherwise bully may cyberbully only when they are very upset, distressed, or angry, often in response to being cyberbullied themselves.

5. *Unintentional cyberbullies*. "Unintentional cyberbullies" also engage in cyberbullying because of a particular set of beliefs or attitudes, but they appear to do so without the active intent to bully that characterizes all-around bullies or only-cyberbullies. One common attitude in this group is that the Internet "doesn't count" or "isn't real," and so what happens there does not particularly hurt anybody or carry any risks. Alternatively, some unintentional cyberbullies may truly be intending to joke, but their writing does not convey the tone of their missives accurately, and their words are taken seriously even though they were not intended to be taken that way. We know that some adults inaccurately estimate the emotional tone of their writing (Kruger, Epley, Parker, & Ng, 2005),

and it is reasonable to assume that children make similarly poor (or even poorer) assessments.

Bullying and cyberbullying carry real risks to schools and communities. These risks include some of the problems described above, such as an elevated risk of involvement in the criminal justice system for children who bully, and an elevated risk of mental health problems among children who are chronic victims of peer abuse. In addition to these individual-specific risks, community-wide risks are incurred by these behaviors. These broader risks require that bullying be recognized as serious in nature and not a "normal" aspect of childhood that adults can ignore.

One community-wide risk involves the legal liabilities incurred by a school district when bullying behaviors occur in a school. We have found that in our interactions with educators, they routinely express fear that disciplining a bully will lead to a lawsuit by the bully's parents. Interested in this prospect, students in the Massachusetts Aggression Reduction Center (MARC; see below) began to research and track bullying lawsuits that have resulted in cash settlements against school systems. The intent was to identify common factors and situations that lead to such lawsuits being waged successfully against schools. Although most of the data are still being analyzed at this writing, one factor emerged immediately as important: These cases were overwhelmingly filed by parents of *victims*—not parents of bullies—who were reacting to what they perceived as the school's indifference to the ongoing victimization of their children. This information suggests that taking disciplinary action against bullies is actually *protective* for a school district. It may be that the parents of bullies either tend not to file legal charges or do not do so successfully (in the sense of obtaining major cash settlements or awards). MARC's finding also suggests that ignoring bullying behavior may actually *increase* the risk a school incurs, rather than decreasing that risk. More analyses are being conducted, and MARC plans to release data on this study soon.

A second significant risk is that of extreme violence. In the final report of a major study, Vossekuil, Fein, Reddy, Borum, and Modzeleski (2002) examined the risk factors leading to all school shootings in the United States between 1974 and 1999. Their analyses found, among other things, a significant link between bullying and school shootings. In approximately two-thirds of the school shootings examined in this study, the shooters described themselves as victims of persistent bullying and taunting, and their attacks as (in part) motivated by a sense of powerlessness and a need to seek revenge. An entire body of research has found associations between being the victim of abuse and an increased likelihood of violent acting out (Spatz Widom, 1989). It is thus no surprise to find that students who are abused by their peers may in turn react violently. Vossekuil et al. (2002) noted that the descriptions of the bullying provided by the school shooters would probably meet legal definitions of harassment if they were applied to the workplace. It is significant that adults enjoy legal protection from such behaviors, but many states still have no laws on the books protecting students against bullying in their schools.

In summary, it is clear that bullying among children in schools is a very destructive behavior, and that for adults to regard it as normal or inevitable behavior is a dangerous attitude. Bullying is abusive behavior that carries significant risks for bullies, victims, bystanders, adults in the school, and the community at large. The consequences of bullying can range from very mild to extremely severe, and potentially lethal. There are certainly other risks in life that carry a greater likelihood of injury (e.g., riding in an automobile), but bullying represents a risk that can be moderated by adults in a motivated community or school. As such, it deserves special attention.

THE MASSACHUSETTS AGGRESSION REDUCTION CENTER

In the fall of 2004, one of us (Elizabeth Englander) began a year as the first Presidential Fellow at Bridgewater State College in Bridgewater, Massachusetts. That year was utilized to set up MARC and launch its model programs to the Massachusetts K–12 educational community. The MARC approach is somewhat different from that of most other experts and centers in the field of bullying prevention. First, MARC is an academic center with a salaried faculty member as its director. It brings services to K–12 education at either no cost or a very low cost to schools. This has removed the profit motive from a field of expertise that previously was largely defined by the marketplace. In addition, MARC utilizes the resources of an academic institution in a very efficient manner. Its services are provided by faculty members, graduate students, and trained undergraduates. The undergraduates working at MARC are particularly valuable as high-status peer role models in helping teenagers in local high schools form and promote their own bullying prevention work in their own schools.

One result of this model has been a high level of services to the education community in Massachusetts. When MARC goes into a school, we focus not only on services, but on assistance with the *implementation* of services (Berends, Bodilly, & Kirby, 2002). While assisting schools with implementation, we work intensively with administrators, classroom teachers, support staff, students, and parent and community groups. After a few years of doing this work, it is apparent to us that several types of communication problems ultimately exacerbate the issue of bullying in schools.

Types of Communication Problems Identified by MARC

Miscommunications between Adults and Children

Many adults give children advice about bullying that is not only incorrect but can actually backfire. Typical advice include statements such as "Just stand up to a bully," or "Your real friends will never do this to you." There is little doubt that these statements are incorrect. Standing up to a bully can actually energize the abusive child, or it may have no effect on the bullying behaviors. Anyone who has witnessed bullying between adolescent girls would never rationally suggest that a friend would never engage in abusive behavior. Although adults do not offer these statements through malice, they are nonetheless inaccurate and unhelpful. Adults are often actually at a loss as to how to rectify a bullying situation. They may resort to old adages or statements they themselves heard as children, or, in some cases, they may actually believe the myths about bullying.

Other miscommunications between adults and children result from generational gaps in technological knowledge. If cyberbullying is occurring, for example, an adult may say to the victim, "Just turn it off!" without understanding how central the virtual world is to a contemporary child or teenager. Finally, adults may, with the best of intentions, focus on "improving" the victim of bullying rather than addressing the bullying behavior itself.

All of these miscommunications result in children failing to consider the adults in their world as significant sources of assistance and support in bullying situations. Adults who say something that is clearly untrue ("You shouldn't care if the other kids laugh"), who offer advice that shows misunderstanding of a child's social situation ("Just turn the computer off"), or who focus on the failings of the victim rather than the failings of the bully send strong messages to children. These failures in understanding and communication suggest to children that adults are not the best persons to address this problem, so it becomes clear that correcting such failures is critical in supporting children against peer abuse and in encouraging reporting by children.[1]

Miscommunications between Educators/Schools and Parents

Being the parent of a child who is being repeatedly victimized by other children at school is very frustrating. Despite an often frantic sense of worry and concern, parents are limited in what they can do. Many parents feel lost when their children come home reporting that they are being picked on or abused at school. They know they want the school to fix the situation, but are unsure how to proceed. See Figure 12.1 for a handout MARC offers to guide parents in coping with the situation when their children report that they are being bullied. Possibly most important is for parents to garner specific, detailed information about when, where, and how the bullying occurs. That information is critically important in helping the school successfully resolve the problem. Communicating such information to the school is an important and proactive step that parents can take to improve the odds that the bullying behavior will be resolved successfully.

A second problem between schools and parents results not from miscommunication but from lack of communication. When parents learn that a bully has been victimizing their child, a natural desire is to know what conse-

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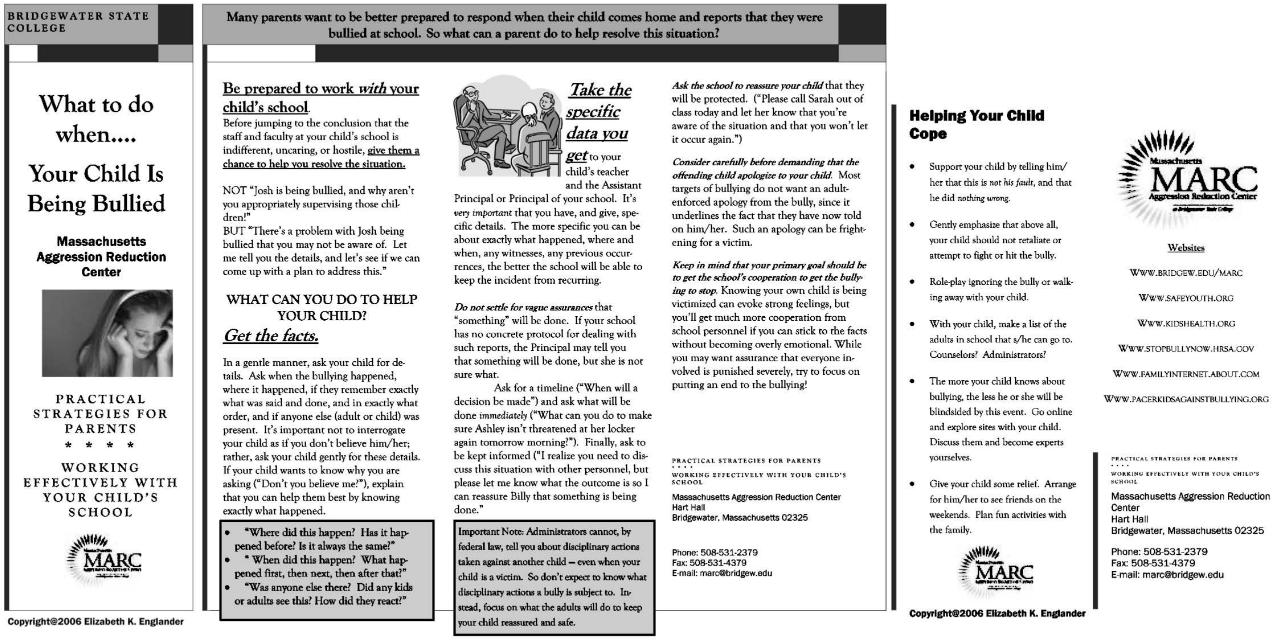
[1] Encouraging reporting by children should be a high priority for all principals in elementary, middle, junior, or high schools. In *every single* school shooting studied by Vossekuil et al. (2002), other children knew about the shooting prior to the actual event but *did not report it* to adults. It is no exaggeration to state that encouraging reporting—especially in middle, junior, and high schools—can literally save lives.



BRIDGEWATER STATE COLLEGE

What to do when....

Your Child Is Being Bullied

Massachusetts Aggression Reduction Center

PRACTICAL STRATEGIES FOR PARENTS

* * * *

WORKING EFFECTIVELY WITH YOUR CHILD'S SCHOOL

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Many parents want to be better prepared to respond when their child comes home and reports that they were bullied at school. So what can a parent do to help resolve this situation?

Be prepared to work *with* your child's school.

Before jumping to the conclusion that the staff and faculty at your child's school is indifferent, uncaring, or hostile, give them a chance to help you resolve the situation.

NOT "Josh is being bullied, and why aren't you appropriately supervising those children!"
BUT "There's a problem with Josh being bullied that you may not be aware of. Let me tell you the details, and let's see if we can come up with a plan to address this."

WHAT CAN YOU DO TO HELP YOUR CHILD?

Get the facts.

In a gentle manner, ask your child for details. Ask when the bullying happened, where it happened, if they remember exactly what was said and done, and in exactly what order, and if anyone else (adult or child) was present. It's important not to interrogate your child as if you don't believe him/her; rather, ask your child gently for these details. If your child wants to know why you are asking ("Don't you believe me?"), explain that you can help them best by knowing exactly what happened.

- "Where did this happen? Has it happened before? Is it always the same?"
- " When did this happen? What happened first, then next, then after that?"
- "Was anyone else there? Did any kids or adults see this? How did they react?"

Take the specific data you get to your child's teacher and the Assistant Principal or Principal of your school. It's *very important* that you have, and give, specific details. The more specific you can be about exactly what happened, where and when, any witnesses, any previous occurrences, the better the school will be able to keep the incident from recurring.

Do not settle for vague assurances that "something" will be done. If your school has no concrete protocol for dealing with such reports, the Principal may tell you that something will be done, but she is not sure what.

Ask for a timeline ("When will a decision be made") and ask what will be done *immediately* ("What can you do to make sure Ashley isn't threatened at her locker again tomorrow morning?"). Finally, ask to be kept informed ("I realize you need to discuss this situation with other personnel, but please let me know what the outcome is so I can reassure Billy that something is being done."

Important Note: Administrators cannot, by federal law, tell you about disciplinary actions taken against another child – even when your child is a victim. So don't expect to know what disciplinary actions a bully is subject to. Instead, focus on what the adults will do to keep your child reassured and safe.

Ask the school to reassure your child that they will be protected. ("Please call Sarah out of class today and let her know that you're aware of the situation and that you won't let it occur again.")

Consider carefully before demanding that the offending child apologize to your child. Most targets of bullying do not want an adult-enforced apology from the bully, since it underlines the fact that they have now told on him/her. Such an apology can be frightening for a victim.

Keep in mind that your primary goal should be to get the school's cooperation to get the bullying to stop. Knowing your own child is being victimized can evoke strong feelings, but you'll get much more cooperation from school personnel if you can stick to the facts without becoming overly emotional. While you may want assurance that everyone involved is punished severely, try to focus on putting an end to the bullying!

PRACTICAL STRATEGIES FOR PARENTS
. . . .
WORKING EFFECTIVELY WITH YOUR CHILD'S SCHOOL

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Helping Your Child Cope

- Support your child by telling him/her that this is *not his fault*, and that he did *nothing wrong*.
- Gently emphasize that above all, your child should not retaliate or attempt to fight or hit the bully.
- Role-play ignoring the bully or walking away with your child.
- With your child, make a list of the adults in school that s/he can go to. Counselors? Administrators?
- The more your child knows about bullying, the less he or she will be blindsided by this event. Go online and explore sites with your child. Discuss them and become experts yourselves.
- Give your child some relief. Arrange for him/her to see friends on the weekends. Plan fun activities with the family.

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Websites

WWW.BRIDGEW.EDU/MARC
WWW.SAFEYOUTH.ORG
WWW.KIDSHEALTH.ORG
WWW.STOPBULLYNOW.HRSA.GOV
WWW.FAMILYINTERNET.ABOUT.COM
WWW.PACERKIDSAGAINSTBULLYING.ORG

PRACTICAL STRATEGIES FOR PARENTS
. . . .
WORKING EFFECTIVELY WITH YOUR CHILD'S SCHOOL

Massachusetts Aggression Reduction Center
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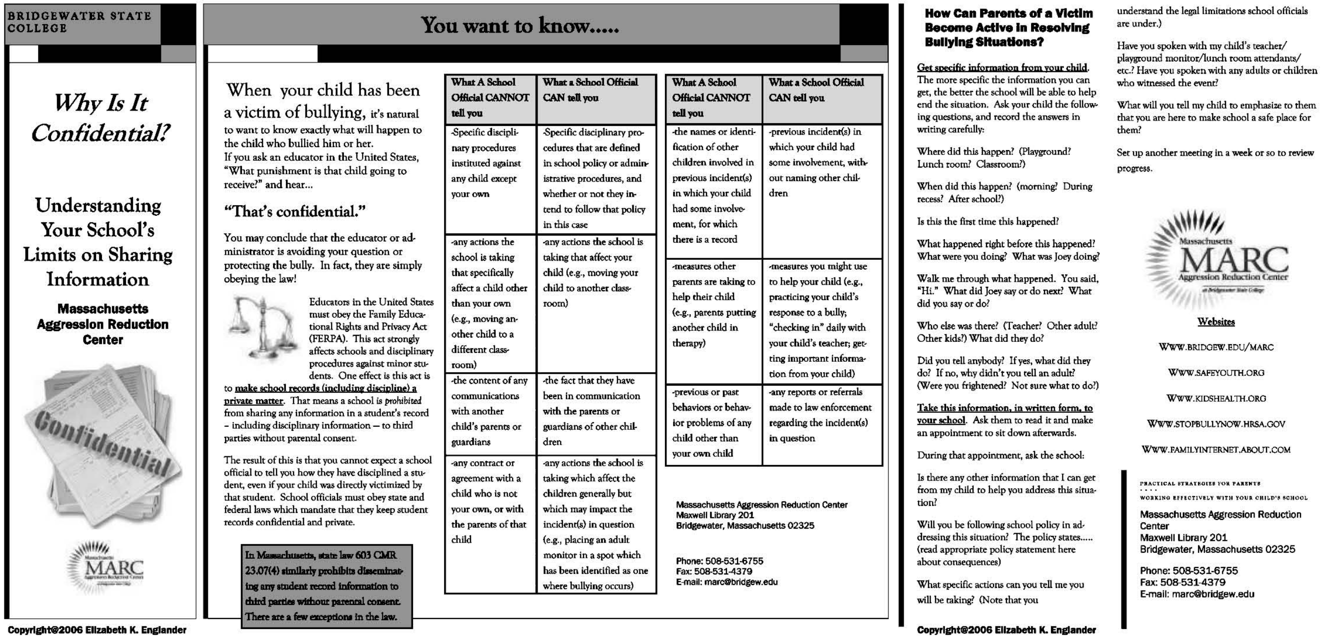
FIGURE 12.1. Parents' guide: *What to do when . . . Your Child Is Being Bullied*. Copyright 2006 by Elizabeth K. Englander. Reprinted by permission.

quences the bully will incur when the activity has been exposed. A victim's parents usually seek this information from the school administrator in charge of discipline (often the assistant principal); however, when the parents ask, "What is going to happen to the bully?," they are often told—and correctly so—that the information is "confidential." In so stating, educators may be citing state law (depending upon the state in which they work) or federal law (the Family Educational Rights and Privacy Act, or FERPA). FERPA specifies that a student's school records, including records of disciplinary actions, can never be disclosed to unauthorized third parties (such as the victim's parents) without the child's parents' consent. Thus, the consequences or punishment incurred by a bully are indeed *confidential information*, even though the parents of a victim may be interested in knowing the outcome of an investigation. The difficulty lies in the communication of this information. Parents, who typically do not know what FERPA is or what it means, frequently seem to misinterpret the school administrator's response of "That's confidential" as one of stonewalling or avoidance. This misinterpretation results from a lack of information and is unfortunate, because it paves the way for hostile and/or unproductive communications between parents and educators. See Figure 12.2 for a handout MARC offers to educate parents about FERPA, so they will understand why administrators describe some information as confidential.

Miscommunications within Schools between Teachers and Administrators

In most workplaces, complex relational dynamics occur between the more powerful individuals and those whose employment they potentially control. Schools are no exception. Administrators hold power over teachers, and this complicates the free flow of information. Unless great care is taken, an interruption of communication between professionals can maintain or even exacerbate bullying behaviors. Communication problems often exist around the topic of bullying. Teachers express to MARC the feeling that they go to the trouble of reporting a child for bullying and then hear nothing further; as far as they can see, the child is simply returned to class with no consequences. This may sometimes be the case, but most administrators are committed to responding to bullying in some way; where they may fall short is not their response but their lack of *feedback to the reporter*. As noted above, federal law does limit the information that administrators can provide to teachers who report bullying. However, a brief assurance to such a teacher that, although it may not be apparent, action is being taken can increase the teacher's morale and sense of being part of the professional team.

Classroom teachers can also improve the quality and the quantity of information they provide to administrators. Concrete, specific details ("He was pinching Sarah's arm while they stood in line") are much more helpful than broad accusations ("He was being mean to Sarah"). It may also be helpful during faculty trainings to emphasize that the beneficiary of reporting bullying abuse is the *victim*, not the administrator; this information may help motivate an increase in reporting.



BRIDGEWATER STATE COLLEGE

Why Is It Confidential?

Understanding Your School's Limits on Sharing Information

Massachusetts Aggression Reduction Center

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You want to know.....

When your child has been a victim of bullying, it's natural to want to know exactly what will happen to the child who bullied him or her.
If you ask an educator in the United States, "What punishment is that child going to receive?" and hear...

"That's confidential."

You may conclude that the educator or administrator is avoiding your question or protecting the bully. In fact, they are simply obeying the law!

Educators in the United States must obey the Family Educational Rights and Privacy Act (FERPA). This act strongly affects schools and disciplinary procedures against minor students. One effect is this act is to <u>make school records (including discipline) a private matter</u>. That means a school is *prohibited* from sharing any information in a student's record – including disciplinary information – to third parties without parental consent.

The result of this is that you cannot expect a school official to tell you how they have disciplined a student, even if your child was directly victimized by that student. School officials must obey state and federal laws which mandate that they keep student records confidential and private.

In Massachusetts, state law 603 CMR 23.07(4) similarly prohibits disseminating any student record information to third parties without parental consent. There are a few exceptions in the law.

What A School Official CANNOT tell you	What a School Official CAN tell you
-Specific disciplinary procedures instituted against any child except your own	-Specific disciplinary procedures that are defined in school policy or administrative procedures, and whether or not they intend to follow that policy in this case
-any actions the school is taking that specifically affect a child other than your own (e.g., moving another child to a different classroom)	-any actions the school is taking that affect your child (e.g., moving your child to another classroom)
-the content of any communications with another child's parents or guardians	-the fact that they have been in communication with the parents or guardians of other children
-any contract or agreement with a child who is not your own, or with the parents of that child	-any actions the school is taking which affect the children generally but which may impact the incident(s) in question (e.g., placing an adult monitor in a spot which has been identified as one where bullying occurs)
-the names or identification of other children involved in previous incident(s) in which your child had some involvement, for which there is a record	-previous incident(s) in which your child had some involvement, without naming other children
-measures other parents are taking to help their child (e.g., parents putting another child in therapy)	-measures you might use to help your child (e.g., practicing your child's response to a bully; "checking in" daily with your child's teacher; getting important information from your child)
-previous or past behaviors or behavior problems of any child other than your own child	-any reports or referrals made to law enforcement regarding the incident(s) in question

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How Can Parents of a Victim Become Active in Resolving Bullying Situations?

<u>Get specific information from your child</u>. The more specific the information you can get, the better the school will be able to help end the situation. Ask your child the following questions, and record the answers in writing carefully:

Where did this happen? (Playground? Lunch room? Classroom?)

When did this happen? (morning? During recess? After school?)

Is this the first time this happened?

What happened right before this happened? What were you doing? What was Joey doing?

Walk me through what happened. You said, "Hi." What did Joey say or do next? What did you say or do?

Who else was there? (Teacher? Other adult? Other kids?) What did they do?

Did you tell anybody? If yes, what did they do? If no, why didn't you tell an adult? (Were you frightened? Not sure what to do?)

<u>Take this information, in written form, to your school</u>. Ask them to read it and make an appointment to sit down afterwards.

During that appointment, ask the school:

Is there any other information that I can get from my child to help you address this situation?

Will you be following school policy in addressing this situation? The policy states..... (read appropriate policy statement here about consequences)

What specific actions can you tell me you will be taking? (Note that you understand the legal limitations school officials are under.)

Have you spoken with my child's teacher/ playground monitor/lunch room attendants/ etc.? Have you spoken with any adults or children who witnessed the event?

What will you tell my child to emphasize to them that you are here to make school a safe place for them?

Set up another meeting in a week or so to review progress.

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<u>Websites</u>

WWW.BRIDGEW.EDU/MARC

WWW.SAFEYOUTH.ORG

WWW.KIDSHEALTH.ORG

WWW.STOPBULLYNOW.HRSA.GOV

WWW.FAMILYINTERNET.ABOUT.COM

PRACTICAL STRATEGIES FOR PARENTS
....
WORKING EFFECTIVELY WITH YOUR CHILD'S SCHOOL

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FIGURE 12.2. Parents' guide: *Why Is It Confidential?* Copyright 2006 by Elizabeth K. Englander. Reprinted by permission.

Other Problems Identified by MARC

Apart from these communication problems, which potentially hamper any school's ability to respond effectively to bullying behaviors, other problems became apparent as MARC's Anti-Bullying Program was being developed. One of these problems was cost. Most organizations that market bullying prevention materials are nonprofit organizations that price their materials as low as possible. Nevertheless, marketplace considerations determine the cost of materials, and this can be prohibitive for many schools. Programs vary in their cost, and it is time-consuming for schools to apply for grants or otherwise pull together the funds to purchase the necessary training materials. These factors can deter educators who might otherwise implement helpful techniques to prevent bullying.

Another problem is lack of assistance with *implementation* of programs. This has been facetiously called the "binder effect" (Englander, 2005). Purchasing a program and having it arrive in a large binder that must then be read, digested, learned, and disseminated can be a daunting task to an overtaxed and underpaid educator who is not an expert on the psychology of bullying and aggression. It has been noted that simply providing programs is not enough; assistance with implementation may greatly increase the odds that a program will be successful (Berends et al., 2002).

Finally, any attempt to change a school climate must reach all sectors of a school community: teachers, support staff, children, administrators, and parents. All too often, schools adopt programs that address only one or two of these sectors, or that only minimally address some of the sectors. For example, reaching out to and engaging parents are major tasks that require innovation and energy. Simply sending a flyer home is not adequate; even "traditional" parent information evenings (e.g., an evening presentation sponsored by a school or Parent–Teacher Organization [PTO]) may be poorly attended. In an era of single-parent families and working couples, asking adults to attend evening programs is not often successful. More innovative methods are needed. MARC is attempting several: holding parent–student breakfasts, airing shows on local cable access channels, and having students involve parents with anti-bullying homework assignments at home.

The MARC Anti-Bullying Program

The MARC Anti-Bullying Program incorporates several elements while attempting to address all these difficulties. It focuses on education and effective response among administrators, teachers, and support staff. It raises awareness and education about bullying among children of all ages, takes advantage of the emotional links elementary-school-age children have with their teachers, and empowers adolescent children to produce and lead the anti-bullying student programs at their own schools. Parents are engaged through innovative methods like those described above, which are tailored to different communities and schools. The program is provided at no cost or a very low cost to schools.

CASE STUDY: MAIN STREET MIDDLE SCHOOL

Referral

Main Street Middle School (not its real name), a suburban middle school with 400 students in grades 6, 7, and 8, was referred to MARC by a colleague who was familiar with our program. The complaint upon intake was that a general atmosphere of support and camaraderie was enjoyed by a few markedly, repeatedly abusive children (bullies) in the school. That is, the school personnel felt that most children did not and would not engage directly in bullying behaviors, but that these same children readily supported bullies by "laughing along" with them or otherwise giving them social support.

Assessment

We began by discussing the presenting problem with administrators and faculty to see how the adults were responding to the situation. Teachers were very conscious of this situation; they generally responded by sitting down with victims and bullies, attempting to mediate between them, and encouraging them to resolve their differences. They reported that these mediations seemed successful at the time, but that the bullying behaviors typically recurred fairly quickly (within a day or two). Other teachers reported feeling baffled when victims appeared to laugh along with bullying children, and in those situations felt at such a loss that they did not respond in any way except to have children "move along."

We also examined the school's policy and procedures. The school's policy was inadequate in some ways; for example, it did forbid bullying or harassment, but its definition lacked the inclusion of "psychological," "verbal," or "electronic" forms of bullying or harassment (very common types). The administration's policy was also to train the faculty but not the support staff; we asked the school to be certain to include training of the support staff, since many of those individuals witnessed even more bullying than classroom teachers did. We also noted that many of the situations and concerns expressed by faculty and support staff alike were fairly typical and representative of many other schools.

Plan for Training/Intervention

When training commenced, teachers and staff members were taught how to distinguish bullying from equal-power conflicts, and how to accurately assess what could be seen as baffling victim behaviors (which might serve to discourage intervention)—for instance, victims laughing along with bullies or protesting that they were "fine." Some of the psychology of victimization was introduced and discussed. We discussed the importance of prompt, consistent, and clear intervention, and described the school's newly developed procedure for dealing with incidents (which included usage of a behavior management chart). The parents in this school were engaged via three mechanisms: (1) a traditional parent education night, sponsored by the school's PTO; (2) a parent–student breakfast, hosted by the school administration and giving parents and children a chance to discuss bullying and to ask questions about the new methodology used by teachers; and (3) the use of a writing assignment in which children interviewed their own parents about their own experiences with bullying during childhood. A student group was formed, consisting partly of volunteers and partly of nominees (to ensure that no one "clique" of students dominated). This group, whose mission was to spearhead anti-bullying efforts within the student population, was trained by undergraduate facilitators from MARC; the facilitators both served as positive, high-status role models and coached students in reconsidering their attitudes about bullying. The students emerged from their training with several concrete anti-bullying projects that they had conceived, planned, and were to implement (these were decidedly *not* adult-conceived or adult-run programs).

Sample Segment of Intervention

Faculty members reported to us in early focus groups that they were often confused when a child was apparently being bullied, but then upon initial intervention the supposed victim frequently protested that the bully and victim were "only fooling around." These encounters left teachers and staff feeling as though they were not sure what they actually saw, and that although it looked clearly inappropriate, perhaps it was actually insignificant. We showed teachers a videotaped example of this circumstance, and then coached them through reinterpreting the victim's behavior. Once they understood why the victim denied the problem (i.e., fear in the bully's presence), we were able to go through a concrete list of appropriate responses (e.g., dismiss the victim and talk with him or her later, talk with the bully immediately, take disciplinary action; etc.).

DISCUSSION/OVERVIEW OF THE MARC PROGRAM

During its first few years, several elements have emerged as the most significant outcomes of the MARC Anti-Bullying Program.

Acknowledging That Educators Are Overwhelmed, and Offering Them Help with Implementation and Assistance

There is no real substitute for an in-depth knowledge of the realities of teaching today. Factors such as low pay, tenure, the pressures of standardized testing, and increased class size may seem unrelated to bullying, but in fact they are quite relevant. Acknowledging these realities renders classroom teachers and support staff more willing and ready to acquire new skills and be more receptive to sources of new information (i.e., experts). In-service trainings, where experts are brought to the school to train its faculty, must be responsive to the taxed and overwhelmed state of mind most educators bring to such trainings. Asking these professionals, for example, to explore their own personal feelings publicly may be well intentioned, but often seems to be interpreted as a waste of time; no one is really receptive to enforced psychotherapy under the guise of education. In contrast, emphasizing very practical, concrete steps that teachers can take away and implement immediately can actively encourage their acceptance of effective interventions.

Prior to developing our faculty training model, we conducted interviews with individual teachers at a variety of schools. The resulting data encouraged us to make our form of training similar to a law enforcement training model, wherein participants are shown a variety of commonly encountered circumstances and coached specifically on how best to respond to each situation, instead of learning esoteric, undergraduate-lecture-style facts. For example, as noted in the case study above, many teachers mentioned that they would see a child bully another child—but that when the two children were called over, the victim would insist that they were "just fooling around" (or something to that effect). In our faculty training model, we present teachers with a short video demonstrating this situation and then give concrete suggestions about effective responding. In the video, we discuss why the victim would negate the incident in the presence of the bully, why such dismissals should be disregarded if an adult clearly feels that a violation of the rules has occurred; and how best to respond immediately.

Using the Academic/Teaching Model Rather Than the Marketplace Model

An academic center reduces and scales costs; removes the profit motive by utilizing a salaried professor as a director, utilizes existing resources very effectively (such as students, computer resources, physical infrastructure, and high levels of knowledge/expertise); and establishes, for the schools seeking services, a dependable source of qualified professionals. Although most organizations and individuals marketing bullying prevention materials are qualified to do so, it may be difficult for K–12 educators to differentiate between those who are truly knowledgeable and those who have tangential expertise. Using academic experts is no panacea, and their knowledge about children's aggression and bullying may not always be as high-quality as desired, but academia generally represents a more dependable source of expertise than that offered by the public marketplace.

Informing Practice with Research

What works with bullies? What types of adult responses actually reduce their abusive behaviors? Olweus, Limber, and Mihalic (1999) and Harris (2004) have both noted that firm limit setting is the most effective adult response, and that clear and decisive actions by adults do more to reduce bullying than slower and vaguer responses. Education and awareness also seem to reduce bullying by reducing the willingness of bystanders to tolerate bullying and the willingness of children to become "eggers" or "henchmen." Research also shows that involvement by parents is a critical aspect of improving the school climate (Desforges & Abouchaar, 2003).

Other research has examined the nature of children who are aggressive and abusive. Despite a pervasive tendency to lump all bullying children into one group, this research suggests the existence of at least two types of bullying children, "bullies" and "eggers" (although the advent of cyberbullying has introduced some new types, as described earlier in this chapter). The bullies–eggers distinction is quite important, because the psychological and cognitive differences between these two types of aggressive children may guide practitioners toward two very different types of adult responses. At MARC, we use the term "bullies" to refer to the first type—children who are motivated to abuse other children by their quest for social power and their sense that this aggressive behavior is a justified and appropriate response to a general perception of a hostile world. Bullies tend to have high self-esteem (Staub, 1999) but cognitive difficulties. Kenneth Dodge (1993) found that such aggressive children had a number of problems with social cognition, such as attributional biases through which they tended to perceive socially ambiguous situations as hostile. Another study (Coleman & Kardash, 1999) found that some aggressive boys were significantly better than nonaggressive boys at recognizing aggressively slanted sentences. Salzer Burks, Laird, Dodge, Pettit, and Bates (1999) studied the immediate factors preceding aggression in children; they found that children with biased "knowledge structures" (i.e., memories that emphasized hostility) processed information in a more negatively biased way and were more likely to develop stable negative cognitive biases and stably aggressive behavior. Similar studies have found that aggressive children attribute fewer positive intentions to people in problem-solving scenarios (Vitaro, Pelletier, & Coutu, 1989).

The second group of aggressive/abusive children, termed "eggers" or "henchmen," seems to be characterized by low self-esteem, as has been noted in some but not all aggressive boys (Staub, 1999). These children, who tend to be lonely and have limited social skills, may show a relationship among jealousy, their low self-esteem, and a tendency to be aggressive (Dittmann, 2005). Because eggers may not be limited by the cognitive distortions found in bullies, they may be more amenable to interventions that force them to confront the consequences of their behaviors.

The final research-based distinction informing our practice is the recognition that bullying and conflict are not the same. Bullying, unlike conflict, is defined by a power differential: A bully is very powerful, while a victim has little or no social power in the situation (Vaillancourt, 2004). This power differential means that, unlike participants in equal-power conflicts, the bully has little or no incentive to "settle" the confrontation; rather, he or she may be invested in its continuation (Englander, 2005). This is an important reason to avoid mediating bully–victim confrontations, since successful mediation requires both parties to have some motivation to resolve the situation (Englander, 2005).

Producing Innovative Programming That Addresses Persistent Obstacles

Two real-life, persistent obstacles are important to overcome if real "climate change" is to be accomplished in any school. First, most curricula for teenagers involve in-class activities, as written and produced by adults. Although there are good data to suggest that some of these programs are generally successful, the question remains whether such adult-produced curricula are the best ways to have adolescents examine their own social behaviors and those of their peers. At MARC, we have decided instead to work with—not against—natural developmental tendencies. Teenagers learn best from their peers and listen most closely to high-status peers. As an academic institution, we have ready access to a large group of extremely high-status peers: college students. For a middle-class high school student, there are few people with higher social status than college students. MARC has begun training college students to go out to area high schools and, in turn, train motivated groups of high school students to conceptualize, implement, and lead the anti-bullying programs in their own schools. This approach has several benefits. First, it puts the onus of responsibility on the high school students themselves. Second, programs conceptualized and led by teenagers hold much more interest than do adult-created programs. Third, it takes advantage of the natural admiration for high-status peers that teenagers exhibit. Finally, it gives college students a chance to engage in direct service work, promote nonviolence and positive social behaviors, and learn new skills.

The second persistent difficulty in changing school climate is engaging the interest of parents. Although parents are naturally motivated to want the best for their children, and many express concern and trepidation over bullying, evening parent programs are no longer the most effective ways to reach a broad variety of parents in a school. MARC addresses this through parent-engaging innovations, some of which are described above. Among the critical elements in this struggle are assisting schools actively with this task (rather than merely telling them they ought to engage parents) and acknowledging the difficulty of being involved in this topic.

CONCLUDING COMMENTS

Many elements of the MARC Anti-Bullying Program are common to other bullying prevention work, as much of it is based on the same body of research, and much of it is approached by practitioners with similar backgrounds and training. The program presented here offers several important differences and innovations, however. We focus more on eggers as intervention points both for children and for adults in a school community. Raising awareness and education are key. Parental engagement is a task that calls for innovation and new ideas, and adolescent engagement is handled through the use of high-status peers as educators and mentors. Preliminary interviews with administrators at the end of MARC's first year indicated that every participating school found these approaches helpful and effective (to varying degrees), and that the adolescent–college student engagement and faculty training were the most helpful elements. The program was further developed in its second year, and research on its effectiveness during that year is currently underway.

Study Questions

1. Consider your own professional position and/or job. What tasks do you do on a daily basis? Now imagine that you will be expected to acquire an entirely new set of psychological skills—for example, helping colleagues with depression or personal problems, or preventing people from gossiping. What practical obstacles would interfere with your ability to launch this new program, and how would being expected to launch such a program make you feel about your position?
2. Think back to your own childhood and about the bullying you may have encountered then. What do you think has changed between then and now? Ask yourself what influences present today might lead children to admire bullying instead of disavowing it.
3. Consider the issue of working in education today. If you do have educators in your discussion group, ask them to remain silent briefly while the rest of the group members list obstacles that they see in the field. Don't confine the discussion to bullying issues; instead, consider all the difficulties in the work area. Consider issues such as funding, public support, and legal liabilities. Next, consult the professional educators in your group, if there are any: How accurate is this description of the difficulties educators face today? Next ask the group to consider if, in combination with the challenges in this field, it would be increasingly difficult to cope with behaviors such as violence and bullying.
4. Review some of the research today on the causes of violence and abuse. (These are obtainable through the text *Understanding Violence* [Englander, 2007].) What is your impression, after completing this reading, of the complexity of the field? Is violence a simpler issue or a more complex one than you originally thought? How does being better educated about the causes of violence affect your attitude toward the possibility of improving bullying behaviors in children?

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Chapter 13

The Crisis of Deaths in Schools

INTERVENTIONS WITH STUDENTS, PARENTS, AND TEACHERS

Roxia B. Bullock

Today's society is inundated with many types of violence, devastation, disaster, trauma, war, and death. Children are exposed to violence and injury, both real and enacted, via television, news, movies, and other media (e.g., video games). Children may also experience violence and death in the home through abuse, illness, and accidents.

These painful experiences may also confront children in school—the special arena of children. When a death occurs in a child's home, the painful experience is taken into the school. On not-so-rare occasions, accidents, illness, violence, and even death occur in classrooms and common areas. A look at the media reveals a long list of school shootings, such as those that occurred in the Cleveland Elementary School in San Diego, California; Bethel Regional High School, in Bethel, Alaska; and Columbine High School in Littleton, Colorado (Coleman, 2004). And even deaths from apparently natural causes may occur at school—as in the case of 5-year-old Jasmine Man, who fell unconscious after eating lunch at 1:30 P.M. at P.S. 184 in Manhattan, was rushed to the hospital, and was "pronounced dead at 2:05 P.M." (Andreatta & Deligiannakis, 2005, p. 11).

When death invades the school and is experienced firsthand, it becomes harder to deal with, because it is real and personal. It is not happening in a movie where the actor comes back the following week healthy and whole, giving an interview; it is not occurring halfway around the world; and it is not happening to a cartoon character. It is real.

This chapter focuses on the elementary school environment and on how death directly touches children at this age level. How do the school personnel deal with death? For example, how do they involve themselves with the unresolved emotions of a child who has lost a sibling? How can school administrators help comfort the child and his or her classmates, and give guidance to teachers and parents? If the death is that of a teacher, how are the children in his or her class(es) in particular, and the school in general, informed and cared for? What resources and methods are available to restore routine and a sense of security?

Schools are generally thought of as places of safety. Five days a week, parents willingly leave their children in the care of trusted and competent professionals. In a figurative sense, at least, the school acts *in loco parentis* during this time; that is, it takes the place of the parents.

GRIEVING AT DIFFERENT DEVELOPMENTAL STAGES

Developmental Perspective

A view described by Erikson (1950) and more recently presented by Davies (2004) is that humans generally grow in predictable stages of development. Each stage lays a foundation for the next stage; mastering the physical, cognitive, emotional, and behavioral skills of each stage is necessary to the successful transition to the next (Greenspan with Benderly, 1997). The developmental perspective teaches us that there are not only expectations for each stage, but also limitations. We see this especially in times of stress, such as the death of a loved one. A 5-year-old child may have difficulty coping and become clingy, act out, withdraw, or become overactive. However, through experience and growth, a child gains coping skills with each successive stage. As caregivers and educators, we need to understand the characteristics of each phase.

Stages of Childhood

Preschoolers (3–4 Years Old)

Most schools today educate children as young as age 3. Although they may be physically well coordinated, on an emotional level preschoolers remain dependent on their attachment relationships to provide feelings of security (Davies, 2004). A preschooler may regress when feeling anxious, scared, or fatigued. If the child has moved through previous stages adequately and is able to maintain object constancy, he or she can tolerate separation from the parent in order to attend school. Cognitively, the child can hold the representation (memory) of the parent in order to carry out the various activities of the school day (Davies, 2004; Mahler, Pine, & Bergman, 1975).

Davies (2004) tells us that the play of preschoolers serves two purposes. Symbolically, it helps them explore how they see the future world and themselves in that world. In addition, a preschooler masters anxiety and stress through play. When this youngster is stressed, he or she reverts to fantasy to understand and cope with that stressful situation. For example, when Grandma dies, the child may see him- or herself as a superhero who possesses some secret magic to fix Grandma so she can come and visit soon.

Piaget (1951) described preschoolers as egocentric, capable of seeing the world only from their perspective. They assume that others see it that way as well. They use magical thinking to explain what is not understandable (Pfeffer, 2000). Preschoolers see themselves as the cause of events. They cannot imagine that the greater world causes events to happen without their input. In the same vein, they confuse fantasy and reality: They impose their fantasies or wishes onto reality, in order to feel more in control and powerful (Davies, 2004). The preschooler perceives death as temporary and reversible. The child experiences intense anxiety and insecurity about separation and/or abandonment, and perceives death in terms of separation (Pfeffer, 2000). This reaction may be intense and brief, and is often accompanied by sleep disturbance and regression manifested in behavioral changes. At this age, if children are told that a person who died went to sleep, they may fear going to sleep themselves.

Children of Early Elementary School Age (5–9 Years Old)

During the early elementary school period, a child develops cognitive ability that includes verbal competency, conceptualization, memory capability, and behavioral constancy (Davies, 2004). He or she is focused on learning, developing peer relationships, and functioning in the school and community environment. The development of language for expression is key to this developmental period. A child in kindergarten through third grade is different in several ways from a child in fourth through eighth grades; therefore, children in these developmental stages of latency are described here as two different groups.

Concrete thinking and a shift from fantasy-based thinking to reality-based thinking characterize the age range of 5–9 years (Davies, 2004). However, when stressed, younger children in this group regress to earlier magical thinking. The superego develops gradually during this period, as evidenced by a keen sense of fairness and feelings of being at fault when expectations are not met. The ability to understand cause and effect is developing, and this can create feelings of guilt if a child perceives him- or herself as the cause of a negative event. Peers and one's status among them becomes very important. The child also moves out into the world by participating in activities, such as sports, clubs, and group activities. Peer interaction expands the child's intellectual and emotional understanding of world events in his or her ever-expanding universe. The child learns the rules of society (Davies, 2004).

The concept of death among 5- to 9-year-olds is that it resembles a person. There is the sense that it can be avoided with good health and youth (Nagy, 1948). Human-like monsters and creatures (as portrayed in the movies and on television) may represent death. Depending on the circumstances, a child during this age period may feel guilt that he or she has in some way caused the death to happen. Children of this age utilize language to try to understand and express their feelings about death, but they also at times may act out and regress to earlier coping in play to express their feelings about death. For example, 6-year-old Johnny told his little sister he wished she would die when she broke his new toy. Two weeks later she was killed in a car accident. He repeatedly played out a scene where he was a superhero saving children from near-death accidents.

Children of Later School Age (9–12 Years Old)

As children mature, their physical coordination becomes better; they develop improved reality testing; they exhibit greater independence; and they also pay greater attention to peer pressure. Abstract thinking and the ability to hold two conflicting ideas at one time (leading to feelings of ambivalence) are characteristic of this stage (Davies, 2004). There is diminished use of fantasy to explain reality. Empathy and altruistic feelings develop to a more adult-like capacity. The beginning of rebelliousness against parental discipline foreshadows the later movement toward independence. In addition, Davies (2004) notes that "school-age children are more capable of autonomously coping with novel situations, separations, and mild circumstances of threat or danger. Attachment needs are also increasingly transferred to peer relationships as friends begin to provide some of the emotional security and satisfaction that have been present in the parent–child relationship" (p. 343).

Death holds a macabre fascination for this age group. Much time may be spent imagining various "gory details" of the event. Explicit depictions of violence seen in movies over the past decade may enhance children's natural fascination. Morality becomes blurred when death is perceived as a justifiable punishment for wrong deeds (Davies, 2004). There is also a need to know about the proper way to express feelings. The death of a loved one can interfere with schoolwork, because a child may be preoccupied with thoughts of the deceased. This preoccupation may be complicated if the child's parents are themselves having difficulty with the death. The child ordinarily expresses the basic feelings of fear, anger, sadness, and possibly guilt. These feelings may give rise to myriad behaviors, such as withdrawal, acting out, repetitive questioning, and anxiety (Figley, Bride, & Mazza, 1997). The 9- to 12-year-old child knows the finality of death (Davies, 2004). This knowledge can cause conflict for the child: He or she may have an urge to regress to fantasy and reverse the death, but knows, with his or her more advanced intellect, that the death is permanent.

SCHOOL-BASED COUNSELING/THERAPY FOR CHILDREN DEALING WITH DEATH

The goal of the school is education, and the task of the school social worker or counselor is to deal with behavioral or emotional problems that interfere with a child's educational progress (Webb, 1999). Therefore, therapeutic interventions or counseling are implemented for the purpose of restoring and enhancing a child's capacity to learn. The type of counseling provided in schools for children dealing with death usually consists of short-term individual crisis intervention (which can include play therapy, as well as cognitive and behavioral techniques) or bereavement groups.

Individual Crisis Intervention

The social worker/counselor's knowledge of developmental stages, ego strengths, superego development, and the nature of attachment can be helpful in working with children in a school (Webb, 2003). The influence that these areas have on educational and emotional development provide insight into children's intellectual capabilities, relationships with peers and teachers, and individual functioning in school and community settings.

Play Therapy

The particular format of therapy with young children often utilizes play as a means of symbolic communication. The school social worker/counselor's office may have to make adjustments for a play therapy approach, and suitable materials and supplies should be made available (Maden, 2000). Basic play therapy supplies include drawing materials, games, small dolls representative of family members (different racial groups), puppets, and clay products (Landreth, 1991; Kaduson & Schaefer, 2000; Malchiodi, 1998; Webb, 1999, 2003, and Chapter 3, this volume). Play therapy is appropriate for elementary-school-age children, and can also be used for children in the junior high school/middle school grades of sixth, seventh, and eighth. Therapeutic board games may be used as a supplement to talking. These methods allow the social worker to learn a great deal about a child's cognitive ability to use strategy, competitive style, interaction with peers or adults, and self-confidence and self-esteem about risk taking.

Cognitive and Behavioral Techniques

"Cognitions refer to one's current thoughts or self-statements, as well as perceptions, memories, appraisals, attributions, tacit beliefs or schemas, attitudes, goals, standards, values, expectations, and images" (Reinecke, Dattilio, & Freeman, 2003, p. 3). Work with children's cognitions about death can be an important part of school-based counseling. Explaining what death is, in age appropriate terminology, is one of the first steps in such work. For example, Amy was a 6-year-old kindergartner whose grandmother had died. She had been told that her grandma went to sleep, and Amy was having some difficulty at bedtime. She eventually asked her counselor, "Will I die if I go to sleep like Grandma?"

COUNSELOR: No, your grandmother died because her heart stopped and her body stopped working, not because she went to sleep.

AMY: Will it start again?

C: No.

A: I can't see her any more?

C: No, but you can remember her and the things you did together.

This example shows a 6-year-old's belief in the reversibility of death, and illustrates how to explain the reality of the situation in terms that the child can understand. It also exemplifies the need for the therapist/counselor to be clear in his or her explanation of death. Clarifying misperceptions and myths about death can be handled in a cognitive psychoeducational manner.

Behavior modification can also be incorporated into school-based work with children who are dealing with death. Specifically, behavior modification charts with stickers can be used by children to earn rewards. The stickers are awarded for engaging in feared behaviors or for positively changing negative behaviors. The chart is set up in single small increments to assure success, and a child gradually moves from easier to more difficult behaviors.

Bereavement Groups

Group counseling can play an appropriate role in helping school-age children in a time of crisis (see Chapters 9 and 14, this volume). As previously mentioned, the school-age child is developing relationships with peers and finds identity, comfort, and knowledge in these. A group of six to eight students in a classroom or office can help students share their feelings and information about death. For a counseling group, each potential group member must be interviewed before the group begins, to determine his or her ability to function in a group environment. This includes each student's willingness to share, as well as his or her level of impulse control and peer relationships (Clifford, 1991). Group counseling can be a useful tool for screening more vulnerable high-risk students who might need more individual counseling to help them through the grieving process (Dudley, 1995; Kaduson & Schaefer, 2000). Because loss takes many forms, bereavement groups can be used for children dealing with other losses besides death, such as parental divorce, death of a pet, and relocation to a new school.

A SCHOOL'S RESPONSE TO AN INDIVIDUAL NEED

Because our schools are seen as a safe haven for our children, it is necessary to address all aspects of children's academic, social, and emotional lives. The multifaceted role of the school social worker/counselor must accommodate the needs of children who are grieving for a parent, grandparent, sibling, friend, or teacher (Webb, 2003). Additionally, the social worker/counselor may need to attend to the needs of school administrators, teachers, and other staff members. This can be done through group meetings, staff meetings, and written correspondence. Parents may also need the guidance of professionals in helping them deal with their children and their own feelings of grief. The school social worker/counselor can disseminate information and provide possible referral resources to help parents help themselves and their children.

THE CASE OF WILLIAM, AGE 9

Family Information

Mother: Sherry Smith, age 36 (occupation: store manager).
Father: Frank Smith, age 38 (occupation: bus driver).
Younger son: William, age 9
Older son: Samuel, age 9 at time of asthma-related death 4 years earlier.

This vignette is a composite of my work and reports in the literature of children dealing with the death of a sibling.

Presenting Problem

William was referred to me, the school social worker/counselor, by his teacher. She reported that he was distracted, preoccupied, and slightly irritable in class, and that his usually average grades were falling. She added that he was constantly talking about his brother, who had died 4 years earlier from an asthma-related episode. William had always openly talked about the death of his brother, Samuel, but he was now speaking about it even more than usual. It is not unusual for children to talk repeatedly about the death of a loved one; the repeating helps them process the loss according to their level of cognitive development (Davies, 2004). I had been assigned to this school for 2 years but had not been aware of Samuel's death, because Samuel had attended a different school that better met his special needs (which included a reading disability, as well as health problems).

William's family was African American and lived in a large metropolitan area. Both parents worked, and they maintained a middle-class socioeconomic lifestyle. The maternal grandmother was involved in William's life; his maternal grandfather had died when William was a baby. His paternal grandparents lived in the South, and he visited them during summer vacation.

As I did not know the history of this child, I called the parents to get permission before meeting with William. I also wanted to meet with the parents first. I have to admit that I was a little uncomfortable thinking about talking to these parents about their dead son and their surviving child's reaction to this tragedy, now 4 years past. I was curious as to what degree the event continued to affect the entire family. The telephone call to the mother was cordial; she seemed eager to discuss William's behavior and academic concerns. We agreed to meet 2 days later.

Assessment

I planned to do an assessment to determine how well the family was coping. Even though Samuel had died 4 years earlier, each family member grieves on a different timetable, not always following the order (denial, bargaining, anger, depression, and acceptance) formulated in the literature (Kübler-Ross,1969). At what stage(s) were these parents and this one surviving child in their grief? How did William cope when his brother first died? How had he been dealing with reminders such as anniversary dates, health issues, separation, and peer relationships? In terms of peer relationships, children often feel different when a family member dies. They may respond with silence to avoid feeling singled out by this "special status" (Webb, 1999). But in this case, William certainly was not keeping silent. What did this special status mean for him?

The Sibling Relationship

The sibling relationship is unique; it is a relationship of history, sharing, rivalry, love, loyalty, jealousy, envy, and identity. Even though siblings share a genetic heritage as well as a familial environment, children from the same family often possess very different physical, intellectual, emotional, and psychological characteristics (Dunn, 1983). The reasons for this remain unclear. Some suggestions are that each child comes to the family with a different constitution; each child has a different relationship with the parents; the parents' marital relationship changes over time; each child chooses different aspects of the family with which to identify; and each child has a different interaction with each of his or her siblings (Dunn, 1983).

First Session

As a general rule, I prefer to meet with parents alone for the first session. This allows me to gather developmental history information, prepare a genogram (although I also do this with children sometimes), and discuss any concerns the parents might have about their child. In this case, I wanted William's parents to be able to talk freely about their concerns without the risk of upsetting their son. I also wanted to obtain a sense of the parents' reaction to the death of their older son, to determine where they were in the grief process, and to learn whether there were any family issues influencing William's behavior. William had been 5 years old at the time of his brother's death; I wanted to know how he had handled that tragedy at that developmental stage, and what their sibling relationship had been like.

Both of William's parents attended our first meeting. I introduced myself, and we began by talking about William and this recent behavioral and academic situation. Both parents were concerned. Education was important to this family, and they wanted William to do well. They reported that their son was involved in school activities and played Little League baseball. He had to work hard to get good grades, but he usually did this with no more than the typical 9-year-old's fussing about homework. His developmental milestones were normal and on target.

I then asked about Samuel's death. Their older son had had serious asthma problems since he was 1 year old. He had received good medical care but required numerous hospitalizations. Because they had heard so often that children outgrow asthma or that the illness becomes less severe, they had not anticipated that he would die from asthma. Of course, they were preoccupied with Samuel's illness and devastated by his death. They had also tried to protect William as much as possible, because William loved his big brother and followed him everywhere, much to the chagrin of Samuel at times. Samuel had good days and even months, but his asthma became progressively worse. At the age of 9, he suffered a severe attack, was hospitalized, and died. Five year-old William kept waiting for Samuel to come home from the hospital, as he had done all the other times. Mr. and Mrs. Smith told William that Samuel's body had become too weak to resist the asthma, and his lungs stopped working. The doctors did everything they could to save Samuel, but they could not. Since his brother's death, William had had an extreme fear of hospitals. (At this point in her narrative, Mrs. Smith began to cry.) William had cried a great deal at that time; he hated to be separated from his brother or any family member.

William had participated in the funeral service, and the family had attended bereavement counseling for an 8-week period. William's parents felt that the counseling had helped, but were not sure they would ever get over their loss. Mrs. Williams turned to her religious faith to help her through these difficult times. Mr. Williams for some time was angry with God for not saving his son, but he later returned to his faith to find purpose in Samuel's death. Now both parents' spiritual beliefs gave them a feeling that Samuel's life had a special purpose, and this was helping them deal with their loss. His death drew this family closer together, with a renewed appreciation for each family member.

Samuel had died in January. It was now the end of November, and William had just turned 9. William was now the same age as Samuel when Samuel died. I explained to his parents that for some children this can be significant in their identity with the deceased sibling and can create anxiety about their own health. I also provided some psychoeducational information about William's developmental stage at the time of Samuel's death and now. Each developmental stage would bring a reminder of things Samuel would not experience, and William might have feelings about this at each of these stages (Figley et al., 1997). I explained that William might feel guilty that he was having experiences at each of these developmental stages that Samuel never had an opportunity to experience. Talking and/or play therapy can help children assimilate this and other aspects of death into their understanding in ways and at a pace they can tolerate (Webb, 1999).

We agreed that I would meet with William for 10 sessions and then determine if more sessions were needed. I sent for William and introduced myself with his parents present. He knew me from seeing me around the school, and knew that other children came to see me when they needed to talk about issues. Mr. and Mrs. Smith agreed to meet with me again after I had conducted a few sessions with William.

Second Session

This was my first session with William. It was crucial to develop trust so that he would open up to me and talk about some of his feelings about his brother's death. I was unsure whether the frequent talking about his brother was a defense mechanism or a way to master anxiety. Also, I wanted to know how much he remembered about his brother and the dying process, and what his feelings had been at that time. I knew that learning all this would take time. Fortunately, William proved to be an affable and engaging child.

Content of Session	*Rationale/Analysis*
Therapist: Hi, how are you today?	
William: Good. Well, my teacher is upset with me because I'm talking all the time. My friend comes to see you. He said you play games.	
T: Yes, I do play games with children, but we also talk. I am a person who talks to children about their worries and problems.	
W: (*Sits down heavily in the chair across from the therapist.*) Yeah, like me. I am not doing so well this year. Well, I did OK on the first report card, but now—I don't know. (*He is quiet for a minute or two.*)	I am impressed with his openness. Maybe his parents prepared him well to be open with me.
T: Is it different than last year?	I want to know if he can draw a comparison, and also if he was having the same concerns about his brother last year. How long has this been going on?
W: A little, but this year is harder.	He has let the talk about game playing go and is articulate, so I want to see how far he can go with this.
T: How so?	
W: I don't know. It is harder, and I am thinking about my brother a lot.	From this, I am guessing his thinking about his brother is interfering with his grades.
T: What are you thinking?	

W: I don't know. (*He is quiet.*) He died.	There it is. He puts it out there and then gets quiet. He is struggling.
T: Yes. Your parents told me.	
W: He was 9 years old when he died. He died of asthma.	
T: How old were you?	
W: I was 5. But I can remember him. He had trouble in school, but everyone liked him. He was fun to play with, even though I was just a little kid. I tried to help take care of him, but my parents took care of him. But I was a little kid. They told me I was just a little kid so, I couldn't do too much.	I am not sure how fast to go, but he is somehow eager to talk about this so I let it go. I am concerned that he will reveal too much too soon and then get scared. I am at this school often, so I know I can be here for him as he needs me. He seems to have a realistic understanding of what he could or could not do as a 5-year-old—or are these defensive words? Does he think he could have helped save his brother?
T: Yes, you were only 5. Five-year-olds can only do certain things to help a sick brother. It sounds like you wish you could have done more.	I hope I am not saying this too soon.
W: I wish I could have done something to save him, but my parents tell me there was nothing anyone could do, not even the doctors.	A 9-year-old, when stressed, may revert to some magical thinking of a younger developmental stage.
T: Five-year-olds cannot fix illness, just like your parents said.	I will use some cognitive psychoeducation to have him understand what 5-year-olds are capable of doing, and thus to give him a more realistic picture of his capacity at 5. I also want to support his parents.
W: Can we play a game? What kind of games do you have?	He has had enough.
T: We can do that. (*Therapist and William play a game. William's play is competitive but age-appropriate.*) You have told me many things today. I would like you to come back next week, so we can talk some more.	I am impressed with this young man. His latency-age cognitive and language abilities are clearly developmentally on target, even though he struggles to keep some strong emotions at bay.
W: Sure, the same day and time?	
T: That will be fine.	

Third and Fourth Sessions

William kept his appointments. The first four sessions were a time of developing trust, and William talked with me about his brother the way he did with others. William not only felt close to his big brother, but idolized him. In situations like this, there is a risk that after the death of someone so adored, William might feel he could never live up to the image he held of Samuel. He also played therapeutic games such as (e.g., The Talking, Feeling, and Doing Game and The Ungame) and card games (e.g., Uno and Crazy Eights). William needed a place to feel safe and not to be judged for talking about his brother, but there was something more as yet unsaid. William was a November baby, a little less mature than his classmates born in the spring months. His brother had been 9 years old (born in June) when he died in January. William had turned 9 in November. It was now January and the holidays were over. There were three triggers at work here for William: (1) the holidays without Samuel; (2) the anniversary of Samuel's death; and (3) the fact that William was now the same age as Samuel had been when he died. I had met with his parents before the holidays and prepared them for another holiday without Samuel. This continued to be a difficult time for the entire family.

Fifth Session

Content of Session	*Rationale/Analysis*
WILLIAM: I didn't want to come back to school, but I had to.	
THERAPIST: How was your holiday?	I say "holiday" rather than "vacation" to see how he deals with this.
W: It was OK. I got a lot of good stuff for Christmas. I was sick on vacation. I thought I was really going to be sick, but my mother said it was just a cold. I worry about being sick. I don't have asthma. My brother had a cold at first, then he couldn't get better, then the doctor said he was going to die.	Here it is. He is now the age that his brother died, and he is comparing symptoms. Worrying about being sick is probably worrying about dying.
T: Do you worry when you get a cold that you will get asthma like your brother?	I am hoping I have not interpreted this too soon.
W: No, I mean a cold can't give you asthma, but maybe a little. He died when he was 9.	Children who experience the death of a sibling often worry that they will die at the same age as their brother or sister. Some feel guilty for living longer and having good health.

T: And you are 9 now. (*William is silent.*) How does it feel for you to be healthy?	I let him have his silence.
W: That is silly, good. But how come he wasn't healthy?	He wants to brush it off, but I want to see if he has any guilt about his health.
T: I don't know the answer to that. Maybe no one does. That makes it harder when no one has the answer. I think it is scarier, because then we never know who will be sick and who will be healthy. Sometimes we do not have any control over that. That is hard.	I am trying to be honest, and to encourage realistic thinking about control.
W: Doctors should know.	He struggles with not having the control or answers—a struggle for a latency-age child who likes to have control and know the answers.
T: We want them to know, but they don't know all the time. That's frustrating for you?	I sense he is angry at the doctors.
W: I guess.	
T: Of course you wanted the doctors to fix Samuel, but they couldn't. Are you angry at them?	I take a leap to define the emotion.
W: Sometimes I am. But I know they tried. My mom says they tried real hard. But he died.	The logic of a latency-age child. He may also be containing his feelings of anger.
T. It is OK to be angry and sad, but it is important to talk about it. Do you talk to your parents?	
W: Sometimes a little. But my mom cries sometimes. So I don't tell her I am mad. I feel different because my brother died.	I hear the "mad." I need to get back to that.
T: You are afraid to make your mom sad. I can talk to your mom next time we meet. Other children tell me just what you are saying—that they feel different when someone in their family dies.	I am pushing the healthy feelings to see if there is any guilt there. I also want to normalize his feeling different.
W: What will you tell her?	He is aware he is healthy. He is also worried about his mother.
T: That you would like to talk to her more often, but you do not want to make her sad.	

W: Well, maybe, but don't tell her I think about getting sick.	
T: Sometimes brothers, like you, worry you might die or get sick at the age your brother died.	I feel there is a therapeutic relationship, so I trust he can accept my question about his fear of dying.
W: (*Quietly*) I know I won't die, but I get sad. Sometimes I throw things around my room. It goes away. But I miss him. Can we play a game?	He needs a break from his feelings.

Sixth through Tenth Sessions

During our last sessions together, William talked some more about how angry he was and how he was afraid to talk about it with his parents because he thought it would upset them. We had one last family session together and discussed how William needed to tell his parents his real feelings. This was a family whose members tried to protect each other from hurtful feelings and thus kept their feelings secret. William's behavior did gradually improve, and his grades also improved with the help of a tutor twice a week. I also recommended that this family attend family therapy for a short period of time, to deal with the continued sadness of their loss and learn how to communicate more effectively with each other about their sadness.

Prognosis

William's brother died when William was 5 years old. At this age, a child does not see death as a permanent state. There was short-term grief counseling for the family at the time of Samuel's death; however, it appears that longer-term counseling would have been beneficial. William was still continually trying to process the realization that his brother was dead. By talking about his brother, he was trying to integrate his brother's death at his own pace.

Moreover, children who experience a death at a young age often re-experience feelings related to the death at different developmental stages. At 9 years old—an age when death is understood as permanent—William appeared to be trying to understand and accept this loss by talking about Samuel repeatedly.

As the anniversary of William's brother's death neared, it stirred up feelings that provided William with an opportunity to use counseling to help resolve some of these feelings and develop new coping mechanisms. An example of such a mechanism would be talking to friends, counselor, and parents. Talking with his parents continued to be a sensitive area, however. Although William was still angry with the doctors for not saving Samuel, longer-term counseling might raise the issue of possible anger with his parents for not saving Samuel. In addition, as William advances to new developmental stages and has the varied experiences that each stage brings, he may feel guilty that he will have the opportunity for such experiences (due to his good health) but that Samuel did not.

I think that William's counseling experience was positive and might lead to future counseling as needed. I predict a positive prognosis for William because he talks easily, is capable of insight, and has the support of a loving family.

Further Comments

Due to the constraints of a school schedule, I set up 10 sessions, as I could consistently commit myself to weekly sessions for only this length of time. Longer-term counseling might have helped William integrate his insights and progress with more stability.

As noted earlier, I referred the family for family counseling, for help in achieving more open communication about Samuel's death. I also planted the seed that William would benefit from further counseling as needed to develop age-appropriate coping mechanisms to deal with his angry feelings about his brother's death. He felt cheated for not having had his older brother for a longer period of time in his life.

"It has been said that death ends only a life: it does not end a relationship" (Bank & Kahn, 1997, p. 271). How parents grieve for a child who has died not only sets an example about how to grieve (openly or closed), but sends a message to the surviving child about how the death of the sibling is to be dealt with now and in the future. In addition, how the parents deal with the death and the identity of the dead child may influence the identity of the surviving child (Bank & Kahn, 1997).

Participating in a group with other children who have experienced the death of a family member might be helpful for William. In a group counseling setting, children do not feel as if they are the only one who has had the experience of the death of a loved one. William would be involved with other children who understood his emotions and behavior. Children who have experienced death often feel different from their peers, as friends and other classmates feel uncomfortable talking to them about the death (Webb, 2002).

A therapist must also consider countertransference issues when counseling a client about death. Whether a counselor has experienced a family member's death, either recently or in childhood, may influence how he or she responds to a client feeling the raw emotions of loss. (See Ryan & Cunningham, Chapter 21, this volume, for a fuller discussion of vicarious traumatization.)

Follow-Up

At the third report card, William had improved and was back to his usual grades. He still talked about Samuel, but more appropriately. When William's brother had died 4 years earlier, William was in kindergarten, and the school had not done much to address William's loss. The school knew the family had gone to bereavement counseling and felt that was enough. The school's primary job is education, but when a crisis or trauma interferes with a child's learning, we, as mental health professionals working in the field of education, have a responsibility to help with other aspects of the child's life. This is illustrated by the next two sections, which describe how a school can respond to the death of a teacher.

A SCHOOL'S RESPONSE TO THE DEATH OF A TEACHER

The School's Preparation for the Crisis

When deaths (or other crises) take place in families or schools, a team of specially trained professionals is called upon to help students and staff. A large metropolitan school system is usually divided into districts or regions; these districts often have a plan for crisis intervention that is sent to each school for the principal to set up and implement if needed. Religious schools may have a team at each individual school and/or may use the services of outside agencies connected to the religious organization to come into the school and provide professional help. This team guides the school personnel through the process until the school personnel can take over support services by themselves. The case example that follows this discussion is a composite illustration of how a public school handled the death of a teacher.

What Is a Crisis Response Team?

Dudley (1995) defines "crisis response teams" as follows:

> Crisis response teams are established to assist in managing tragedies that have significant impact on schools, i.e., student or staff deaths, critically ill or injured students/staff, terminal illness, natural disasters, hostage or abduction situations. These teams are designed to provide assistance to students and staff, preschool through high school.

Guidelines for Counselors and Other School Personnel

When a teacher, a parent, or a student dies, a sequence of steps can be taken to guide the administrators, teachers, staff, and students through the tragedy to recovery. As Dudley (1995) notes, it is important to have a plan, even though the plan may vary with different events. The following outline presents a plan to deal with the impending and eventual death of a teacher. As the case example in the next section will show, not every school can implement all of the steps in every situation. The crisis response is divided into three phases.

Phase I: Introduction and accurate information

- Select and organize a crisis response team.
- Establish a general plan for possible crisis situations (specifics can be worked out for each individual event).

- Inform the principal of the impending death.
- Have the principal meet with the crisis team.
- Have the principal and crisis team leader contact the dying teacher and his or her family, and brief the rest of the crisis team with accurate information.

Phase II: Crisis intervention procedures

- Discuss the school's plan with the family. Obtain the family's consent to implement specific procedures.
- Prepare an informational letter to parents that states the facts pertaining to the death of the teacher, and discusses how to help their children cope with the event. Remind parents and teachers that children and adults deal with death differently, and provide any available information regarding the funeral.
- Encourage parents to maintain children's usual routines, make sure children get proper amounts of rest, and try to avoid unnecessary separations for several months.
- Inform students, using age-appropriate language, what has happened. This can be done by the classroom teacher with a written script if he or she is capable of doing so, or by a crisis team member. The purpose of a script is to provide consistency to deal with facts and dispel rumors.
- Allot time for discussion and questions by the students.
- Identify at-risk students for extra counseling.
- Reduce work and homework assignments for 2 or 3 days. This will allow children time to process their thoughts and feelings about the death without feeling overwhelmed with work.
- Set up separate rooms for students and staff, for talking or counseling as needed.
- Instruct teachers to allow students to go to counseling centers.
- Maintain a predictable class schedule and rules to provide support and consistency; children feel safe when the school provides structure and security.
- Help teachers recognize their own emotions, and encourage teachers to express their feelings appropriately (e.g., "I also feel sad about what happened").
- Understand that children may regress, but that previously mastered behaviors will return.
- Understand that children respond differently; some will act out, and some will withdraw.
- Maintain communication with all teachers, staff, and parents to oversee how students are coping with the event combined with the usual demands of their everyday lives.
- Follow up on high-risk children as needed, and make referrals if necessary.

Phase III: Debriefing (see "Concluding Comments," below, for some caveats about debriefing)

- Debrief the teachers.
- Debrief the crisis team (Dudley, 1995).
- Follow up with on-site personnel as needed after the crisis team has left.

THE CASE OF MRS. JONES

To Tell or Not to Tell?

Mrs. Jones was a 60-year-old first-grade teacher who had missed many days of work since the beginning of the school year, due to illness. She was eventually diagnosed with cancer. The prognosis was poor; she was told that she had less than a year to live. Mrs. Jones had been a beloved member of the ABC School faculty for 25 years. She had taught first grade for the last 10 years. Most of the children in the school knew her, as her class was one of their first experiences in the academic world.

After her last absence of 1 week, Mrs. Jones told her principal, Mrs. Green, that she had been diagnosed with cancer but would like to continue working as long as possible. Mrs. Jones promised that if her condition began to deteriorate, she would inform the principal and leave, so as not to put the children at any academic or emotional risk. This would also give the principal time to find an appropriate substitute teacher for the remainder of the school year.

The principal had three situations to consider. First, she wanted to show caring and compassion for Mrs. Jones. Second, she knew she had to take care of the current first graders (who had known Mrs. Jones for 5 months of the school year, since it was now January). Third, she had to consider an entire student population. Mrs. Jones had been a part of the school environment for many years, and most of the students in the school either had had her as a first-grade teacher or knew her from other roles she had performed over the years.

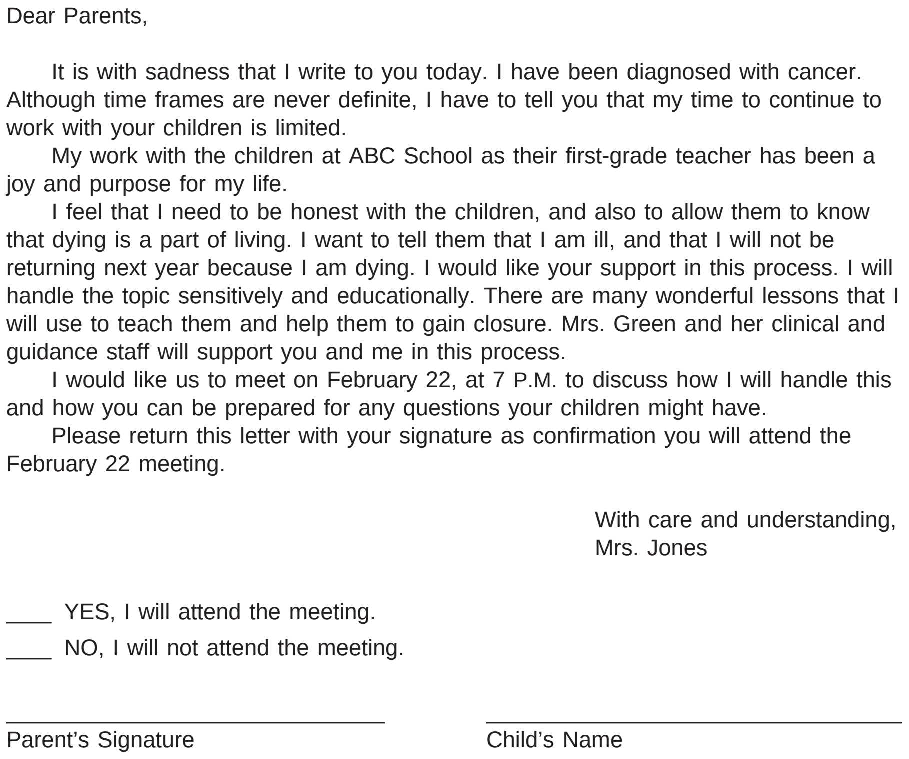
The school social worker was called in to provide knowledge and guidance. Not only the developmental age of the first-grade children had to be considered, but also each of the developmental stages of the different grades, as each age group would respond differently.

After a month had passed, it was apparent that Mrs. Jones was growing weaker because of her chemotherapy treatments and the progression of the disease. She could not go on teaching much longer. Should she tell the children that she was ill and dying, or simply that she had decided to retire, would be leaving the school, and would not be coming back? These were big decisions to make, not just for the children but for Mrs. Jones. Could she handle telling the children that she was dying? First-grade children (ages 6–7) do not see death as permanent. If they were told in June, they might expect Mrs. Jones to return in September as usual. Timing was going to be a major issue. Was Mrs. Jones ready? How would the parents respond to their children being told? What if they refused to allow their children to be told? How would this be dealt with?

The principal, the social worker, and Mrs. Jones met. The decision was left to Mrs. Jones and would be respected. Mrs. Jones agreed to tell the children, but in her own way. She thought it best to prepare them with some lessons about death, utilizing some of the wonderful books that are available for such lessons. She also asked for the support of the social worker. She was sure she could tell the children that she was sick; she was not sure she could tell them that she was dying. She would have to wait and see.

Devising a Crisis Plan

The principal asked Mrs. Jones if she would mind consulting with the crisis team for advice and guidance in this sensitive situation. Mrs. Jones welcomed the support. The crisis team was called into the situation. The team leader, in coordination with the school social worker and guidance counselor, agreed that the parents of the first-grade class should be informed about the situation in the form of a letter. A letter was written (see Figure 13.1), informing the parents of Mrs. Jones's illness and mentioning that educational materials about loss, death, and dying would be presented. In addition, it was stated that a meeting with the par-



Dear Parents,

It is with sadness that I write to you today. I have been diagnosed with cancer. Although time frames are never definite, I have to tell you that my time to continue to work with your children is limited.

My work with the children at ABC School as their first-grade teacher has been a joy and purpose for my life.

I feel that I need to be honest with the children, and also to allow them to know that dying is a part of living. I want to tell them that I am ill, and that I will not be returning next year because I am dying. I would like your support in this process. I will handle the topic sensitively and educationally. There are many wonderful lessons that I will use to teach them and help them to gain closure. Mrs. Green and her clinical and guidance staff will support you and me in this process.

I would like us to meet on February 22, at 7 P.M. to discuss how I will handle this and how you can be prepared for any questions your children might have.

Please return this letter with your signature as confirmation you will attend the February 22 meeting.

With care and understanding,
Mrs. Jones

____ YES, I will attend the meeting.
____ NO, I will not attend the meeting.

______________________________ Parent's Signature

______________________________ Child's Name

FIGURE 13.1. The letter that was sent to the parents of Mrs. Jones's first graders.

ents of the first-grade class would supplement the letter and further help educate parents about how to handle questions that their children might bring home.

The principal also wanted the staff to know about Mrs. Jones's illness. She asked Mrs. Jones's permission to meet with the staff and present the facts, since rumors were beginning to be heard. Mrs. Jones acknowledged that this would be important, but she was not ready to be present at such a meeting. She gave the principal permission to tell the staff. The principal asked the crisis team to be present at this staff meeting. The team consisted of four members and one alternate (a social worker, a sixth-grade math teacher, a parent, a fourth-grade teacher, and a guidance counselor) who had volunteered for this particular school. On the second Monday of each month, faculty meetings were held. The principal wanted to make the announcement at the next meeting, to be held the following week. She would invite all staff personnel from the entire school to be present. She would use the crisis team and her own staff guidance counselor and social worker to provide support for any faculty or staff members feeling particularly vulnerable (e.g., those who were close friends of Mrs. Jones, suffering from recent deaths in their own families, suffering from illness themselves, or anxious about the topic of death).

The faculty meeting took place on the following Monday. The principal made the announcement and gave information about Mrs. Jones and her illness. Many of the teachers already knew, since nothing moves faster than a rumor along a school grapevine. However, hearing the "official" news made it real. Many teachers cried. The principal had allowed time for discussion and questions. She was modeling what she wanted the teachers to do when it was time for them to tell their students about Mrs. Jones. She would prepare a written statement for the teachers to read, so that all of the student population would receive the same factual message. As emotions calmed, the principal told the teachers that she and her clinical and guidance staff would be available for them. She also discussed how important it was for those feeling especially sad and/or upset to seek help through their union employee assistance program, private counseling, or the crisis team.

Implementing the Crisis Plan

The time to implement the crisis plan came sooner than expected. Mrs. Jones was rushed to the hospital that evening and died 2 days later. The cancer had metastasized to her brain. Mrs. Jones's family informed the principal of her death the evening that she died (Wednesday); at that time, the principal obtained the family's consent to carry out her plan of informing the students. She then called an emergency meeting of the crisis team, and they agreed to call a special faculty meeting at the end of the school day on Thursday. At the faculty meeting, a written presentation was handed out for each teacher to read to his or her class after announcements on Friday morning. After the reading, the teachers would allow time for discussion and the answering of questions. During the discussion period, teachers would pay particular attention to any student who might seem especially vulnerable. Those who might be considered as potentially high-risk were defined as students particularly close to Mrs. Jones, those who had experienced the death or illness of a family member or friend, those in her first-grade class, or any students having a difficult time with this death. Signs of this high risk would be withdrawal, acting out, or deep sadness. Teachers were to submit the names of these students to the principal, who would then pass them on to the social worker or counselor for further intervention. Two rooms would be set up where the children could go if they needed to spend time alone or to talk more in depth with the social worker, the counselor, or another crisis team member. At the same time, the school would maintain its usual schedule. The only difference would be to put less emphasis on tests and homework to be assigned for this day and over this weekend. The principal would keep the staff and parents updated regarding the family's wishes in terms of wake times and funeral arrangements.

Because it was now Friday, a letter was sent home with the children informing parents of the death of Mrs. Jones. The school's plan was outlined in the letter, and parents were asked to give extra comfort to their children and to be aware of how separation at this time might affect their children.

The following Monday, the crisis team leader agreed to keep his team in the school for the coming week. Then the in-school clinical and guidance staff would take over. The two rooms set aside for student use would be kept open for the week. After that, the social worker and guidance counselor would be available for students who needed attention, especially those determined to be high-risk.

After the funeral, the principal asked three members of the staff and three students to plan a memorial for Mrs. Jones. Her family would be consulted to give consent, and there would be some form of permanent plaque placed in the school to commemorate Mrs. Jones's achievements.

Follow-Up

A committee of teachers and students designed a plaque and a simple and tasteful memorial service, approximately 2 months after Mrs. Jones's death, to honor and commemorate her life and work. The service was held in the auditorium, and the entire school attended. Teachers were prepared for a discussion when the students returned to class. Again, teachers were told to be aware of any high-risk students and make the appropriate referrals to the social worker or guidance counselor. The service went well; members of Mrs. Jones's family were present. They thanked the students and staff for their support during this time. A few students were identified as high-risk and were referred appropriately.

As noted earlier in this chapter, not all children (or adults) grieve on the same timetable. Later in the school year, some children experienced regression triggered by an event in their lives that stimulated the memory and their feelings of the loss of Mrs. Jones. In June, the termination of the school year also brought reminders of loss and separation, especially for the younger children. Teachers and parents were reminded of this possibility and were given some strategies to deal with behaviors and emotions as they arose.

CONCLUDING COMMENTS

Crisis by definition is a time of reduced coping mechanisms, uncertainty, and anxiety. However, as James and Gilliland (2004) point out, it is also a time of opportunity. Adults and children alike are ready for a solution to help them through the painful experience. An example of this is how a well-trained crisis team and school staff can facilitate emotional and personal growth.

A school is a structured and routine-based setting; this should hold true during a crisis as well. The crisis team and trained staff can help ensure the structure that makes the children (and adults) feel safe and secure. Times of crisis also necessitate the need for flexibility within the structure, such as the reduction of homework assignments and test schedules. However, the school needs to return to normal functioning as soon as possible (Fitzpatrick, 2006).

The needs of the crisis team and faculty also need to be addressed. This can be best accomplished through debriefing modalities, such as crisis incident stress debriefing (CISD) or the model developed by Nancy Sanford of the Los Angeles United School District (Fitzpatrick, 2006). A debriefing program follows specific steps: introduction and explanation, cognitive responses, emotional reactions, a concluding cognitive summary of events, psychoeducational information, and referrals if necessary. Recently, some of these debriefing methodologies have been criticized for not being as effective as was previously believed. Groopman (2004), in an article in *The New Yorker*, discussed the discouraging results of the current psychological debriefing methods. In some cases, researchers even claim that debriefing may interfere with recovery. However, after a crisis event some form of closure is needed, whether it be CISD or some other form of debriefing. It is important to process what has taken place, what mistakes were made (if any), and how the process can be improved upon. It is important to allow the crisis team members to process their thoughts and feelings about the event, in order to bring full closure to this time period. Debriefing acknowledges that professionals involved with a crisis also need to take care of their own anxieties.

Study Questions

1. Imagine that 2 months after the death of Mrs. Jones, the first-grade teacher talks to you, the social worker, about a 6-year-old girl in her class who continues to show regressed behavior (withdrawal, difficulty separating from her mother in the morning to come to school, daydreaming, not doing classwork, asking for more help with classwork than is necessary). Her grandmother is in the hospital due to diabetes. The parents have recently separated. How would you intervene to get this child to function

at her previous level? Compare a "normal" 6-year-old's reaction to loss with this child's.

2. What personality characteristics and skills do the crisis team leader and other crisis team members need to play their roles efficiently and productively?
3. Do you think the social worker should have given William more than 10 sessions? If so, how many sessions would you suggest? How would more sessions have benefited William? Would a referral to "outside" therapy have been better from the beginning?
4. How might you organize a group of children who have experienced a death in their family? What would be different about this group compared to other types of groups, such as study skills groups or conflict resolution groups?

Role-Play Exercises

1. Role-play a teacher telling a class of first graders about Mrs. Jones's death. Have a group of classmates role-play the children and ask the sorts of questions that first graders would ask.
2. Role-play two factions of parents. The first group wants the school to intervene and tell the children about the death of Mrs. Jones through a lesson about death and dying. The second group, for a variety of reasons, does not want the school to talk or teach about death and dying.

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Chapter 14

Helping Forgotten Victims

USING ACTIVITY GROUPS
WITH CHILDREN WHO WITNESS VIOLENCE

Danielle Nisivoccia
Maxine Lynn

A child is having lunch with her parents in an outdoor cafe when suddenly a man is knifed in front of them. She makes a comment about its being like TV and finishes her French fries. Later that night, the child awakens from a nightmare. Seven other children witness a drive-by shooting in which one of their friends is killed in the crossfire. In a third incident, a child watches her dad become violent with her mom, but realizes that if she tells anyone "they" may take her away. Another child witnesses his mom being raped, but is sworn to secrecy by her. Children who enter our country as immigrants have often witnessed the violence of war and/or terrorism, but they fear reprisals if they tell anyone. Although the mass media are filled with violence, the witnessing of violent acts has varying effects on different individuals. The tragedy of September 11, 2001, and its aftermath brought the violence of terrorism and war to U.S. soil. The lack of safety and security now is in the mainstream consciousness of every child and adult.

CHILDREN AND VIOLENCE

The United States continues to be the most violent country in the industrialized world, and violence is becoming a defining characteristic of U.S. culture. Public health officials have identified violence as one of the most significant U.S. public health issues (Dulmus & Hilarski, 2002; Osofsky, 1997; Stein et al., 2003). An estimated 3.3 to 10 million children each year witness the abuse of a parent or a caretaker (Berkowitz & Marans, 2006; Children's Defense Fund, 2005). As many as 80–90% of all young children (Guterman & Cameron, 1997), and three out of four elementary and high school students of color in urban areas, have witnessed at least one violent act in the home or community (Garbarino, Dubrow, Kostelny, & Pardo, 1992; Lorion & Saltzman, 1993). The Centers for Disease Control and Prevention estimate that 9 million children per year are exposed to violence in their neighborhoods (Berkowitz & Marans, 2006). Although children's exposure to violence is disproportionately high in poor and minority communities in the inner city, rural children are not immune to such exposure and its consequences (Lynch, 2006; Stein et al., 2003). The last decade has been plagued with an epidemic of violence in white middle-class schools in Alaska, Arkansas, Colorado, Florida, Kentucky, Michigan, Mississippi, and Oregon (Bowen, Bowen, Richman, & Woolley, 2002), demonstrating the fact that no child is protected from the possibility of witnessing violence.

Children who witness violence in their homes and communities can be profoundly traumatized (Aisenberg & Mennen, 2001; Dulmus & Hilarski, 2002; Webb, 2003, 2004). While researchers are beginning to focus on children's exposure to violence, studies usually have a dual focus on children who witness violence and those who are victims. Often, the youth who are indirectly affected become "forgotten victims." Adults either are unaware of the impact of such exposure on children or try to minimize it, fearing that talking about the violence will upset the children. Some parents are profoundly emotionally distressed themselves by the violent events and cannot be supportive or protect their children, thus negatively influencing the children's perception and response (Aisenberg & Mennen, 2000; Berkowitz & Marans, 2006; Garbarino, 2001; Goff & Schwerdtfeger, 2004). One study found that greater mother–child agreement about the effects of children's exposure to violence was associated with better psychological well-being (Ceballo, Dahl, Aretakis, & Ramirez, 2001).

Children are rarely given the opportunity, particularly in the case of community violence, to express and identify emotions related to the events (Sieger, Rojas-Vilches, McKinney, & Renk, 2004). Young children are especially vulnerable because of their limited life experiences and immature cognitive, emotional, and social development (Garbarino, 2001). This chapter focuses on the use of activity groups in the school for latency-age children who have witnessed violence; such groups give them opportunities to process the experiences they have witnessed. The chapter also illustrates, through a discussion of the stages of group development, activities that are best suited to group members' age, gender, and type of experience.

DEVELOPMENTAL ISSUES AND VIOLENCE

Latency-age children (those aged between 7 and 12 years) are developing their cognitive, sensorimotor, moral, affective, and social learning skills. Their world has begun to shift from the family to the outside world of school, neighborhood, peer groups, and nonparental adult role models. They are increasingly able to tolerate frustration, to derive satisfaction from activities, to think operationally, to solve problems, to understand right and wrong, and to empathize with others. They are working on their emerging sense of competence, autonomy, relatedness, and identity (Garbarino et al., 1992; Germain, 1991). Therefore, latency-age children who witness the disturbing effects of violence may experience feelings of anxiety, anger, denial, fear, and helplessness (Aisenberg & Mennen, 2000; Berkowitz & Marans, 2006; Osofsky, 1997). Indeed, these children may be particularly vulnerable to such reactions because of their less defined and developed cognitive and verbal resources, immature defenses, limited life experiences, and coping abilities. A child's perception of the violent event(s), the nature of the exposure to violence, and the meaning the child attaches to it all play a critical role in understanding how the child interprets the stressor(s) of violence and how it affects him or her (Aisenberg & Mennen, 2000).

Exposure to violence does not mean that a child will necessarily develop debilitating symptoms. Tripartite assessment (see Webb, 1999, 2003, and Chapter 1, this volume) should be conducted to evaluate the individual child factors, the nature of the situation (e.g., intensity, proximity, familiarity), and factors in the home and social environment. Children who have witnessed violence often develop a range of physical, emotional, cognitive, and behavioral difficulties characterized by the giving up of play, avoidance of closeness, lack of trust, fear of adults, shame, and isolation (Lewis-O'Connor, Sharps, Humphreys, Gary, & Campbell, 2006; Lynch, 2006; Whitlock, 1997). Their behavioral symptoms may include somatizating (e.g., headaches, stomachaches, eating and sleeping disturbances, bowel problems) or gaps in language development, poor impulse control, difficulty handling separation, and poor peer relationships. Sometimes they regress to earlier modes of relating (Osofsky, 1997). For many children, school performance declines, motivation lessens, behavior becomes disruptive, and they experience a sense of helplessness (Aisenberg & Mennen, 2000; Berkowitz & Marans, 2006; Flannery, 2006; Osofsky, 1997; Sieger et al., 2004; Stein et al., 2003). Many of these symptoms are congruent with those of posttraumatic stress disorder (PTSD). However, some authors have pointed out that youth may not show all the criteria for a diagnosis of PTSD, but nonetheless may be very disturbed by stress-related symptoms (Benoit, 2006). Children's adjustment difficulties may not be directly noticed, except among boys who externalize with aggressive acts, and among girls who internalize with somatization, anxiety, or depression. It has been suggested that chronic community violence exposure may be more strongly associated with externalizing symptoms, regardless of gender (Flannery, 2006; Lynch, 2006; Youngstrom, Weist, & Albus, 2003). When the symptoms are ignored, children's sense of basic trust, autonomy, and initiative may be compromised (Aisenberg & Mennen, 2000; Lorion & Saltzman, 1993) and their risk for emotional and behavioral problems increases (Garbarino, 2001; Sieger et al., 2004).

THE USE OF GROUPS WITH CHILDREN

Group work and programmed activities can provide a nurturing environment for children exposed to violence by giving them opportunities to have corrective emotional experiences and to increase their interpersonal skills. The use of groups builds on the strengths of the children and helps move them beyond the experiences they have witnessed. Interventions include helping the children learn mutual aid processes, thereby increasing their social networks (Garbarino, 2001; Lynn & Nisivoccia, 2005).

When children witness violent acts in their home or communities, they often have confused generational boundaries, and role reversal can occur (Roseby & Johnston, 1995). A group is an arena for children to redefine their boundaries through activities. Major content areas that can be worked with through various group activities include the following (Grusznski, Brink, & Edleson, 1988; Peled & Davis, 1995):

- Expressions of feelings
- Issues of isolation and shame
- Establishing responsibility for the violence
- Conflict resolution

The group becomes an ideal modality because it breaks isolation, deals with shame, raises self-esteem, helps children recognize effective limits, and enhances relatedness. The curative elements of peer interaction, validation of experiences, universalization, therapeutic leadership of adults, and the "group as a benign mother" highlight the importance of this model (Ceballo, 2000; Connors, Schamess, & Strieder, 1997).

The group work approach that is most useful is developed from the mainstream model of social group work. This model fosters the development of a "natural helping network" that takes into account each child in his or her environment. The group leader intervenes to develop support and mutual aid (Haran, 1988; Papell & Rothman, 1980). The goals of the group include learning to trust, to share, to make friends, to recognize feelings, and to deal with conflicts.

Children often reenact family scenes in the group, or use it to get negative attention because this is how they get their needs met at home. The group permits the youngsters to develop new patterns of interaction in ways other than through abusive interaction. The group also provides an arena to define violence, offers effective ways to cope with the feelings that are generated, and allows members to experience cohesiveness and mutual aid. Finally, the group normalizes the fear and anxiety with which most children react to violence (Ceballo, 2000).

Activity Programming in Groups

The use of structured group activities has a rich history in social group work (Henry, 1992; Malekoff, 2004; Northen & Kurland, 2001). Activity is the "vehicle through which relationships are made and the interests of the group and its members are fulfilled" (Middleman, 1968, p. 67). The values and purposes of program activities with children's groups include opportunities to create something imaginative and expressive. This approach allows the group leader to directly observe each member's interactions, to encourage less articulate members to express thoughts and feelings through the activities, to encourage a sense of mutual aid and mastery, and to improve members' self-esteem (Northen & Kurland, 2001). The activity must relate to the group's needs and abilities, based on its stage of development (Lynn & Nisivoccia, 2001).

Children symbolize and express their conscious and unconscious worlds through play and action. Activity itself is viewed as therapeutic (Henry, 1992; Lynn & Nisivoccia, 2001; Middleman, 1968). Erikson (1963) viewed play as a child's means of achieving mastery over traumatic experiences, and it can be viewed as the most natural method of self-healing. Children use play to reconstruct traumatic experiences and to reenact these repetitively (Garbarino, 2001; Webb, 1999; Whitlock, 1997). All activities in the group have dual purposes—namely, mastery and increasing self-awareness (Halperin, 2001). Group leaders need to demonstrate concern and protection, and to keep in mind that the process is more important than completing an activity (Lynn & Nisivoccia, 2005).

Before using an activity, a group leader should consider the following: (1) the purposes that the activity will achieve; (2) the relationship demand (i.e., the degree of intimacy vs. distance, sharing vs. competition, cooperation vs. conflict); (3) the focus (i.e., individual, group, or both); (4) required skills; (5) decision-making opportunities for each individual and the group; (6) appropriateness to members' life situations; (7) cultural sensitivity; (8) impact on behavioral expression; (9) timing within the session and the stage of development of the group; and (10) availability of resources (Northen & Kurland, 2001). The leader must interpret the way that the activity is being used as a metaphor for behavior (Wilson & Ryland, 1949), as well as assume responsibility for directing the activity.

Roles of the Group Leader

In order to create a safe enough environment for traumatized children, the many roles of the group leader/therapist/social group worker need to include those of supporter, protector, director, and mediator. Schwartz (1976) emphasizes that the leader has the function of mediating the transaction in which the individual and group reach out to each other. Since traumatized children often have poor peer relationships and little trust in adults, the group activity can help bridge the gap by assuming the qualities of a holding environment and "a benign mother" (Lee & Nisivoccia-Park, 1983; Scheidlinger, 1974; Slavson & Schieffer, 1975; Winnicott, 1965). The leader needs to plan each activity carefully to fit in with the group's goals, the dynamics of the particular group, the group's stage of development, and the individual needs of the children, as well as to establish clear limits and help group members deal with reality. The group leader needs to have a sense of control, be in touch with his or her own reactions, and be open to examining his or her personal history of witnessing violence.

Planning: Specifics in Getting Started

In planning a group, one needs to decide on the membership criteria. Ideally, the size should be six to eight children of similar gender and age, with no more than a 3-year difference in age among members. The goal is to plan a group in which individual members will feel comfortable, and in which the group as a whole can develop cohesion. Security and feeling safe are critical elements in developing a support group (Garbarino, 2001). When the group is culturally and racially diverse, it offers opportunities to explore differences, and it exposes members to a range of values. Children who are too psychotic, who act extremely aggressively, and/or who have no social skills will not benefit from or cannot tolerate a group experience. Occasionally, the horrific details of the violence may have so traumatized a child that he or she cannot function in a group. Also, this child's experiences may frighten other children. Such children may require a period of individual treatment before they can benefit from a group experience.

Stages of Group Development

Groups in general follow discrete and dynamic stages of development (Henry, 1992; Northen & Kurland, 2001). The particular type of group described in this chapter is time-limited to 12 sessions and develops within a sequence of four stages. Table 14.1 describes the goals and activities for each session, and indicates in a footnote how the sessions are linked to the four-stage model. The table is a guide and should not lock the leader into the pressure of having to complete or even initiate any one activity. The goals are separated into process and content objectives. Process goals are characterized by the relationships between members, the relationships among members and the leader, and the dynamics of the group as a whole. The content goals are the actualizations of the tasks (Toseland & Rivas, 2005).

The first stage constitutes the beginning of the group. This stage sets the context for work and the need to create a safe environment. The children are wondering what is going to happen and who will take care of them. They worry about whether the leader and other members will like them, whether they will be expected to share any secrets, and what dangers may exist in the group. Their behavior is generally characterized by approach and avoidance. A clear contract must be developed. Sharing personal experiences is encouraged. Through activities, ground rules are set, cohesion is built, and a safe environment is created.

The second stage involves more sharing of content related to personal issues and self-disclosure (Northen & Kurland, 2001). Activities are introduced that

TABLE 14.1. Characteristics of Stages of Group Development and Agenda of Activities

Session	Content goals	Process goals	Activities
1	Defining purpose and contract Establishing confidentiality Setting norms Getting acquainted	Seeking commonalties Creating nurturing environment	Name tags Pass the Squeeze
2	Sharing information and feelings Recontracting Further exploration	Building group cohesion and trust Reinforcing norms	Drawing family picture Defining violence Rumor Clinic Giving group a name
3	Defining violence Dealing with violence	Defining power and control issues Setting boundaries	Good Hand, Bad Hand Rumor Clinic
4	Exploring meaning of violence and how it affects each person	Defining power and control issues Recontracting	Good Hand, Bad Hand Role play
5	Working through issues of violence Teaching problem solving	Enhancing coping and adaptation Building cohesion, intimacy	Enactment of a story
6	Exploring violent words Self-disclosure Working through issues of isolation	Building trust and mutual aid	Using code words to make a poster
7	Connecting the external violent words Separating the members from the violent acts	Feeling vulnerable Risking Dealing with ambivalence	Tic-Tac-Toe Wish List
8	Establishing responsibility Separating the members from the violent acts	Conflict resolution Testing group norms Differentiation	Creating a song Identifying feelings with ball game
9	Developing protection Understanding members' feelings	Increasing coping, adaptation, and conflict resolution skills to enhance cohesion	Role play Put on a play Taping one feeling on each member's back and having others guess it
10	Understanding the differences among feelings, needs, and thoughts Defining what is important	Recognizing and accepting each other as distinct individuals	Drawing a person/member and filling in head (thoughts), heart (feelings), and stomach (needs)
11	Raising termination issues Creating rituals for endings	Helping members begin to separate from the group Dealing with regression	Composing a group letter or poem Planning a party
12	Talking about gains Sharing feelings about losses and leaving	Allowing the boundaries to dissipate Helping members cope with sadness	Writing and exchanging goodbye cards Writing one thing each member did not get from the group Party

Note. Session I corresponds to the first stage of the four-stage model described in text; sessions 2–3 correspond to the second stage; sessions 4–10 correspond to the middle stage; and sessions 11–12 correspond to the final stage.

build empathy. Power and control issues are also heightened in this stage, and setting clear, firm limits is important. The leader needs to reduce obstacles so that the middle stage can develop.

The middle stage consists of the essential work of the group. Members discuss openly how their experiences of violence have affected them. Their abilities to hear each other, express feelings, and self-disclose increase. Problem solving and mutual aid skills are utilized. The leader can be less active as members help each other to work on their tasks.

The final stage deals with the meaning of separation and reviews the gains made by each member. The children focus on the meaning of endings and on how they can approach other adults or peers with their concerns and feelings about violence.

CASE EXAMPLE: A GROUP FOR CHILD WITNESSES OF VIOLENCE

Group Formation

The site for this group was an urban public school. School can help children cope with various life crises (Lynn & Nisivoccia, 2001), and because children are together on a daily basis, helping efforts can be made in a timely manner.

In the group presented here, the referral sources included guidance counselors and teachers. Initially, reasons for referral included prior knowledge of what a child had experienced, a drop in grades and/or in attendance, or interpersonal difficulties with peers or teachers. Each child was seen individually to learn about her concerns and tell her about the group. Parents were sent a permission slip home and were encouraged to call with questions.

The group was held in a small classroom. Each session was 45 minutes long and corresponded to a music period in the school. A snack was served at each meeting, because doing so provides immediate nurturance and helps children initiate talking (Keyser, Seelaus, & Kahn, 2000). The group was composed of nine girls between 9 and 11 years of age. Twelve girls were chosen initially, but two girls' parents refused to sign permission slips, and one girl did not want to be in the group.

The children in the group were in regular classes and had not yet demonstrated symptoms severe enough to require an intervention from a mental health clinic. This group model could be utilized in other settings (e.g., a shelter, an after-school program, or a clinic). As noted earlier, the nature and reality of crises for children such as these often go unnoticed in comparison with those children who are directly affected by violence. Such children may come to the school's attention only when they hide after a loud noise, when their grades go down, when they fear a class trip, when they create disturbing drawings, when they make frequent trips to the nurse or bathroom, when they become withdrawn during play periods, or when they suddenly become involved in aggressive acts.

Membership of the Group

- Josie was 10 years old and was born in a South American country. She had witnessed her mother being raped in her country of origin. Teachers reported that she got upset if any boy brushed by her.
- Rosemarie was 9½ years old and of Puerto Rican background. She had witnessed a knife fight in school and had told her parent that she did not want to return to school. The guidance counselor noted that the child was restless and reported having nightmares.
- Kenyetta was 9 years old and African American. She had also witnessed the knife fight and had told everyone in graphic detail about the incident. She was aggressive, was often involved in fights herself, and often argued with the teachers and staff.
- Alexandra, 11 years old, was of Croatian background and a recent immigrant. Her family reported that she had witnessed terrorists murdering her neighbors. She was quiet and daydreamed a lot, and was enrolled in an English-as-a-second-language class. Teachers reported that she often complained of stomachaches and did not eat much.
- Laura, 10½ years old, was African American. She had told her teacher that her parents were always fighting. The teacher reported that she was late to school, was sleepy in class, had disheveled clothes, and refused to participate in school activities. Her grades were also dropping.
- Kay (Kahital), 10 years old, was from India. She was terrified to come to school after witnessing a bike being taken from another child. The teacher reported that her parents were overly concerned and came to school over the incident.
- Maria, 11 years old, was of Hispanic background. A bullet from a drive-by shooting had come through her bedroom window. She was shy and reticent. The teacher reported that she asked to have her seat in class moved away from the window.
- Rosa, 10 years old, was of Hispanic background. She lived with her mother and two siblings in a shelter for victims of domestic violence. The teacher reported that she stole crayons, trinkets, and pennies.
- Evelina 10 years old, was a tall, light-skinned interracial child who was ungainly and awkward. She also lived in the shelter for victims of domestic violence with her mother. The teacher reported that the child was isolated and was the victim of bullying and teasing.

Session 1

The room was arranged with chairs around a table. Everyone was there except Evelina, who was absent. The girls looked around, but didn't say much at first. They were greeted by Beth, the social worker who was the leader of this group (and who is the "I" in what follows).

Content of Session	*Rationale/Analysis*
Rosemarie: I'm missing music. Kenyetta: Why are we here? Laura: Are we in trouble? Leader: Let me remind you remind you who I am. I'm Beth, a social worker who works at this school 2 days a week. And no, you're not in trouble. You were invited to the group because it has come to our attention that each of you has seen something terrible and may have some feelings about it. When I met with each of you alone, some of you shared that you wanted to make friends and had some concerns about school. We will be meeting every week for 12 weeks for one class period. I guess we should start off getting to know one another.	Approach/avoidance behavior. The girls want to know why they are here and why they were put in the group. They are anxious that they may be in trouble and need clarification about why they have been invited. I quickly reintroduce myself and reflect their concerns about being in trouble by letting them know that they are not in trouble. The purpose and brief contract are shared, along with the fact that "they are all in the same boat" because of having "seen something terrible." By making the unknown known and letting them know what they have in common, I am taking a risk: I am "saying the taboo" in an attempt to lessen the beginning anxiety.
Kenyetta: I already know Rosemarie. Laura: What if I don't want to stay? (*Maria arrives late and explains that she had to go to the bathroom.*)	
Rosa: Can we have the cookies now?	Again, approach–avoidance behavior. I decide not to address it as an individual issue.
(*In unison, the rest of them either nod their heads yes or say, "Yes, cookies, cookies."*)	Food is both nurturing and fills a void. It also gives the group something "safer" to focus on and affords a worker an opportunity to be giving. Usually I give it at the end as gratification and a reward.
Leader: Let me share how I think we might do things together, and then I'd like to hear from you if this is OK. Each meeting we will have an activity where we will do something together. Then we will have a snack, and we'll talk about the activity. No one has to come to the	I "lend my vision" about the structure and expectation of the group members and what they would be doing, thus beginning to establish the norms of the group. At this point I remind them that I have spoken with each one of them previously alone, and that they do not have to come to the group or

group, but when we met alone, you all seemed to like the idea. You also don't have to participate in the activity. What happens between all of you and myself is not to be shared outside of the room; it's sort of like our secret. However, if there are times that secrets have to be shared with the school or your parents, I will talk to you privately about it.	participate in the activity if they don't want to. The issue of confidentiality is presented in a child's language.
LAURA: Well, what secret would you tell?	The group is getting a better understanding about what secrets stay in the group and what I may have to share.
LEADER: Things about someone hurting you.	
KENYETTA: I think that we should have the cookies first.	Kenyetta is a fairly aggressive, needy child. I will have to do some limit setting.
KAY: Well, I can wait a little while.	
LEADER: Let's find out who wants the cookies now.	I am trying to assess each individual's needs.
(*They all yell, "Me, me, me."*)	
LEADER: (*Goes over to get the snacks and places them on the table.*)	I decide to serve the snacks now, to create a more nurturing environment and to continue to engage the group in getting to know one another.
KENYETTA: There are 24 cookies. We each get 3.	
LEADER: That's really good. Would you like to help pass out the cookies? . . . I'm concerned that not everyone knows who everybody is in here yet. I have some name tags, stickers, and crayons on the table; each of you can write the name that you'd like to be called in the group and decorate it any way that you'd like.	The girls' anxieties are lessening with the snack, and so are mine. I begin the activity of decorating a name tag as a way of getting acquainted and talking about themselves.
(*The girls begin decorating their name tags while eating the cookies.*)	
LEADER: I see that you are finished. Before you put them on, I'd like for each of you to introduce yourself and tell us how you decorated your name tag. I'm going to show you: My name is Beth and I've drawn a cookie, because we've	I participate in the activity and use my name tag as a model.

started the group off with cookies today.	
Rosemarie: Can I be first?	
Leader: Yes.	
Rosemarie: I am Rosemarie and I drew a sun, 'cause I like the color yellow on sunny days.	This child makes a positive beginning.
Kenyetta: I am Kenyetta, and I used red, black, and green, 'cause those are the colors of my flag.	
Alexandra: I thought that our flag was red, white, and blue?	
Kenyetta: That is the American flag. I am talking about Africa.	The activity is helping individuals to begin disclosing safe information about themselves and to get a sense of one another.
Kay: I'm from Bombay. . . .	
Leader: Who hasn't gone yet?	
(*The other girls introduce themselves in turn.*)	
Leader: Now I'd like to introduce a game that deals with signals we send each other. These will be signals through your hands. It starts off with my squeezing one person's hand a certain number of times, and that person passes it on to the next person, and so on. The last person has to tell us how many squeezes it was.	After making sure that everyone gets an opportunity to participate in the introductions, I want to help them get acquainted through another (more intimate/physical) activity—the game of Pass the Squeeze.
Rosa: This is like Telephone.	Rosa's remarks makes the unknown known, as Telephone is a game that some of them know.
Josie: (*Nervously*) Do we really have to squeeze hands?	I wonder if this is "too much, too fast" for this child. She appears to have difficulty with touching.
Kenyetta: How else are you going to play the game?	
Leader: Remember, you don't have to play if you don't want to. Does any one else have any feelings about it?	I again reinforce the contract and state that they do not have to participate in an activity if they don't want to. By doing so, I continue to make a safe environment and allow each member to proceed at her own pace. One member verbalizes what might be an issue for some of the other girls.
Kay: It is OK to squeeze hands, 'cause we're all girls here.	
Leader: Who wants to start?	

Rosa: I'll start. (*Reaches for leader's hand, giving it three firm squeezes.*)	
(*The girls play the game, and the last person whose hand got squeezed calls out the number of squeezes which she received, only to find out that it was different from Rosa's first squeeze. The group does this several times, laughing and determined to "get it right."*)	Everyone is participating. It appears to be a nonthreatening intervention and a way to begin to establish a sense of trust and getting acquainted. It also gives the girls an opportunity to move around the room.
Leader: We only have a little time left today. How did you think the meeting went?	I am letting the group know that time is about up and asking for feedback.
Kenyetta: I liked the cookies. Could we name the group?	A sign that the members are beginning to get invested and want to take some ownership of the group.
(*Two other member chime in, "Yes, let's name the group."*)	
Leader: OK, next week bring in your ideas for names. I'm still curious to know what the rest of you thought about today.	I am impressed that they want to take ownership of the group by naming it. I ask for feedback so that the group can be tailored to the girls' needs.
Rosemarie: Can we meet at a different time? I don't like to miss music.	She is not convinced that she wants to remain in the group.
Maria: I had a good time.	

Session 2

The group arrived. The snacks were not yet out. I (Beth) welcomed and recognized Evelina, who was not at the first meeting, and asked her to introduce herself.

Content of Session	*Rationale/Analysis*
Leader: Would someone tell Evelina what the group is about and what we did last week?	I want to make sure that the new member knows what the group is about. I also use the opportunity to reinforce the purpose, renegoiate the contract of the group, and get a sense of the girls' perception of it.
Kenyetta: We ate cookies and played a game! Are we having cookies now?	It is apparent that they are not ready to talk about the purpose of the group, as they do not feel safe with the members, me, or the process. I do not push them, but continue the activities of
Leader: Does anyone else want to share why we are meeting?	

(*The members have blank looks on their faces.*)	getting acquainted and naming the group, which will help to establish initial cohesion.
Leader: *(Repeats the group's purpose from the first meeting and asks each member to introduce herself to the new member, which they proceed to do. She then reminds them that the last week they decided to name the group, and asks if they had any ideas. The group members seem to like this idea. They call out the name of their favorite singing groups, such as the Spice Girls, and began to sing some of the songs.)*	
KENYETTA: What about the Dream Girls?	
LAURA: Who are they? (*Kenyetta gets out of her seat and begins to imitate them.*)	
ROSA: Let's call it Selina's Sisters.	I know that some of the members have nightmares. Is this a way to approach this topic in disguise?
ALEXANDRA: Why not Beth's Girls?	
KENYETTA: I think Dream Girls is the best.	
KAY: Why is that?	
KENYETTA: Because the Dream Girls always sing happy songs, and Selina was murdered.	This is the first spontaneous reference to violence in the group. I am a little surprised that it happened so soon.
ALEXANDRA: Who is Selina? How did she get murdered?	
JOSIE: Some crazy friend of hers shot her.	
ROSEMARIE: Yeah, that was sad.	
JOSIE: That is why you got to be careful about making friends.	She is revealing her defenses.
LEADER: I wonder—what about making friends in the group?	There are several group dynamics going on: early power and control issues; decision making; issues of ethnic diversity; and information about violence and murder. As the group needs to become a safe place, I address possible concerns that they may have in the group. Again, I am "saying the taboo."
(*The group members chime in and say, "Not in here," "We are not going to kill each other here."*)	
KAY: I'm not so sure that we're going to make friends.	
KENYETTA: So are we going to name the group?	

Leader: It seems like we've got several things to deal with today, all of them important. One is naming the group. The other is your concerns about being a member of the group, and if you remember, one of the purposes of our group is to deal with some of the bad things that you have seen. . . . I think that this might be a good time to talk about how you make a decision as a group.	I point out that there are several important issues going on, and I focus on what it is like to be a member of a group and the group's purpose. Thus I am building and reinforcing group norms. I wonder if they all are ready to accept "deal[ing] with some of the bad things . . . " as a purpose, however. I intervene to establish boundaries and group norms.
Kay: In our class we vote.	Two of the members self-disclose.
Maria: Yeah, but at my house my mother always decides.	
Leader: In this group everyone needs to be involved in making a decision.	
(*After a brief period of deliberating, the group decides to take a vote, and the Dream Girls win. The leader notes that Kenyetta has bullied Evelina and Alexandra into voting for the Dream Girls. The leader asks the group members if they are all satisfied with the results, and some say yes more enthusiastically than others.*)	The deliberating process gives the members a greater opportunity to share their preferences (although it also reveals an early problem with group dynamics). It also offers them an early opportunity to make a decision together about the group, thereby increasing their sense of ownership and cohesion.
Leader: The next thing that will help us get to know each other is for you to draw a picture of your family or who you live with.	This activity will help the members get acquainted and continue to share information and feelings.
(*Several members remark, "I can't draw."*)	
Leader: I can't draw much either.	I share/self-disclose that I too am not good at drawing.
(*Rosa reaches over and takes a whole bunch of crayons. Evelina breaks hers in half and hides them.*)	
Kenyetta: (*Yelling*) I don't have the colors I need.	
Rosemarie: (*In exasperation*) I just can't do this.	
(The leader gets up and moves to help Rosemarie. Kenyetta jumps up and loudly demands that Rosa give her some of the	Initially, I ignore the group's behavior and focus on Rosemarie, realizing that some of the others cannot share. The

crayons. Rosa says some profanity in Spanish. Kay, Alexandra, and Maria make various efforts to end the dispute. The rest of the members are engaged in the drawing.) Alexandra: Are we going to have a snack today? Leader: Yes, it's about that time, and over the snack we can continue talking about this and your family drawings.	conflict between Kenyetta and Rosa appears to raise anxiety in other group members. I recognize that time is almost up and encourage them to continue the discussion over the snacks as well as to share their family drawings, thus making a demand for work.
(*The leader asks Alexandra and Josie to give out the snacks. Then the group talks about setting rules. The members discuss cursing in the group and what to do when they are angry at each other. They share their drawings. The leader notices that there is some embarrassment. She asks the group members whether perhaps they did not want to do the activity and were afraid to tell her. She reinforces that they do not have to participate in every activity.*)	Again, I am trying to build and reinforce group norms, educating them about the rules of behavior and expectations of being a group member. I am trying to be accepting and nonjudgmental about the members' behavior, and I do not comment on the cursing. I note that there are several very strong members in this group, who happen to be split along racial lines. Kay is becoming the superego and indigenous leader.

Session 3

From the first two sessions, I identified the following themes: (1) learning to be in the group and (2) the setting of boundaries. There was an emerging scapegoat, Kenyetta. The members were fearful of sharing information about themselves, and there was concern about getting their needs met. Conflicts were developing that were characteristic of power and control. I was also aware that there were only 10 more sessions, and that the group members needed to accomplish the purpose of defining and dealing with their experiences of violence.

Power and control issues were some of the obstacles that prevented the group members from accomplishing these tasks. Specifically, several members arrived at this meeting reporting that last week Kenyetta had been in a lunchroom fight, had hit an aide, and had been suspended from school. Rosemarie angrily announced that she would not stay in the group if Kenyetta was in it. When Kenyetta arrived, Rosemarie repeated that she wanted to leave (but did not). I recognized the anger. I asked Kenyetta to give her version of the lunchroom incident, since I did not know what had happened (nor did several other members). Kay, Laura, and several other members supported this. Maria quietly said that she "didn't like this." Kenyetta gave a very animated account: A girl knocked over her tray, spilled her milk, and did not even say she was sorry. "Words" were exchanged, and the girl hit Kenyetta. She went on to explain that she had to defend herself, and that when the aide came to separate them, she "attacked" Kenyetta—and so the aide got hit as well. Rosemarie yelled at Kenyetta that she was a "bitch" and that she (Rosemarie) had seen the whole thing.

I used the fight situation as an opportunity to connect what was going on in their outside lives to what was going on in the group and the group's purpose. Laura shared how awful she felt about fighting, and added that her parents did it all the time. Rosemarie and Kenyetta started confronting each other on who should leave the group. I told them that who might stay or go was my decision, and suggested that maybe they were mad at me for the way I was leading the group, or angry that I could not stop bad things from happening. The members began talking about having to protect themselves in a "bad" world, and discussed how "bad things happen from fighting." I reflected on their sharing having seen bad things happen or having had bad things happen to them or people they knew and/or loved. I then suggested an activity that deals with the issues of good and bad.

Content of Session	*Rationale/Analysis*
(*The leader introduces the Good Hand, Bad Hand activity. She distributes pieces of paper and asks the members first to trace both their hands, and then to fill in the outline of one hand with all the good things that a hand can do and the other with all the bad things. During the activity, the members ask the leader how to spell various words. After the members complete the activity, the leader begins to process what they did.*)	The activity provides a structure to raise the issues in a less threatening manner. The polarization of Kenyetta and Rosemarie is extreme, and there needs to be some deflection. This is characteristic of the power and control stage of group development. I hope that the activity will accomplish this purpose.
LEADER: You all have some very creative hands. Would anyone like to tell us about the good hand?	
KAY: A good hand can draw pretty pictures, can pet a cat, and hug you.	
MARIA: Yeah. It can put makeup and fingernail polish on.	
JOSIE: It can make you feel better.	
(*Some of the other members continue to share what a good hand can do.*)	
LEADER: Now, let's talk about what a bad hand can do.	
KENYETTA: (*Quickly, shouting*) Pulls hair, punches, pinches.	
LEADER: Thanks, Kenyetta, now let's give someone else a turn.	
EVELINA: Yeah, slaps.	

Rosa: Steals, fights with other people.

Maria: Shoots.

Josie: (*Quietly*) Do you mean a gun?

Kenyetta: Cutting someone with a knife.

Laura: That's terrible.

Leader: It seems as if you girls have a lot of similar ideas, and that we can find ways to work on this stuff together.

(*The leader asks the members to cut out their individual hands and put them together on a large piece of poster board to make a group picture. While this is going on, Rosemarie and Kenyetta keep an appreciable distance. The snack is served. During this time, the leader asks the group members how they thought the meeting went today.*)

Throughout the activity, the members often have the same thing written down. This demonstrates the commonality the members have with each other.

I am struggling to build cohesion. The group has become a parallel process, and a microcosm of their lives and what they have experienced. I feel upset that they have seen so much violence.

Session 3 was characterized by the intensity of power and control issues and by testing of me as the leader. These were enacted, with two major themes emerging; Kenyetta and Rosemarie represented the polarization of these themes. The issues of a group member exhibiting violence and another member's witnessing the violence paralleled the reason for the group's being. This led to members' heightened anxiety, which precipitated scapegoating and the group's resistance. The girls were uncomfortable being in the group and were looking for protection from me.

Session 4

I realized that I must deal with the powerful content generated in session 3, exemplified in the struggle between Kenyetta and Rosemarie. These were obstacles that could get the group stuck at this point and prevent the work from occurring. The group needed to develop cohesion and work on issues of trust, which would lead to recontracting. Therefore, the activity must be a powerful intervention to help the group move into this challenge.

Upon arrival, I thankfully noted that the group members were not as angry as when they left the previous week. I then initiated a series of activities.

As I was using a blackboard to brainstorm a list of all the things they would like to have happen in the group and another list of things that they would not like to have happen in the group, I noted a heightening of the struggle between Kenyetta and Rosemarie. The two girls did not seem to want to deal with this directly, so I suggested that two other members of the group do a role play of Kenyetta and Rosemarie together in the group. Kay and Laura volunteered. At one point, I asked Kay (as Kenyetta) to think about what Rosemarie might be feeling, and asked Laura (as Rosemarie) to think about what Kenyetta might be feeling. The real Kenyetta shouted out, "This is stupid! I want to stop!" Kay pointed out that Kenyetta sounded scared. Kenyetta replied with bravado, "I'm not scared of anything." I used this incident to explore different experiences that had scared the group members. Several of the girls shared experiences. However, Josie's experience (in which she described in detail how a man had attacked her mother) was the most profound.

Upon hearing Josie's story, the group became silent. Several girls started to cry, and others asked Josie what she did when this was happening. Josie described how she hid and afterwards helped her mother. I reinforced the importance of expressing the range of feelings, including sadness and anger. The girls elaborated about how mean and violent men and boys can be. This sharing created a common feeling, which increased cohesiveness.

The final activity was having the members draw a picture of something that would make them feel better. I asked them to share their pictures with other members. It is important to note that I did not come into this session with prescribed activities, but chose to let the activities emerge from the content and process of the group.

Sessions 5 and 6

During session 5 the group worked through some of the early power and control issues, which were characterized by "storming" and conflict (Northen & Kurland, 2001). Although the tensions between Kenyetta and Rosemarie had not totally dissipated, some conflict resolution had taken place. The members had also begun to take risks by sharing some of their experiences and feelings about violence; thus the work of the group had begun. I now needed to use the activities to increase the feeling of cohesion, sharing, belonging and mutual aid.

In session 6 I introduced the activity of making a collective poster containing code words that would generalize the members' feelings about the group and violence. It would also give them an opportunity to work and play together. I decided to have them work as one large group to enhance cohesion.

I began the activity by giving each member an index card, colored markers, and glue. I told them that I was going to call out a word, and on the card they were to write another word that it reminded them of, or that they associated with it. I then said, "The word that I am thinking of is 'group.' " The girls looked around, and someone said, "What does 'group' remind me of?" When they had finished, I gave them another index card. I told them that the second word I was thinking of was "violence," and that they were to do the same as they did for the first word. The group members were pensive, but continued the activity by writing on the second index card. I continued by giving them a large piece of poster board and telling them that they were to place and glue all their individual cards into some kind of meaningful whole-group picture or design. As they did this, there was a lot of discussion as to how it would be laid out and what their design should look like. Although there was some debate regarding what it would look like, the members were able to work together with minimal intervention from me. After they glued the cards on, I told the members to use the markers to draw connections between the cards. Again, there was a lot of process regarding the connections and meaning attached to them. Finally, I told them to draw or write anything they would like to have on the poster that was missing. I asked them to talk among themselves about the poster and explain it to me. (The poster is depicted in Figure 14.1.)

Kay began by saying that the cards in the top left corner in a circle were the words representing "group." They had written the name "Dream Girls" around these words to represent their group's name. The various words on the associated index cards were "school," "snacks," "fun," "talking," and so forth. Rosemarie jumped in and took over, explaining that the words representing "violence" (e.g., "scared," "mean," "hate," "hide"), which were running like railroad tracks off the poster board with arrows, were "stuff" that they were trying to get rid of and that made them feel bad. They all took turns explaining the various connections that they made, with some making reference to the "scary stuff" that they had experienced, and wishing and dreaming that it would go away.

Clearly, the group was learning how to work together, as the members began to share more of their feelings about violence during this session. Although the tensions and cliques had not totally dissolved, the group was feeling safer for the members, and mutual aid was developing.

Session 7

I believed that the girls might now be able to risk more about themselves and their experiences with violence, and I introduced the game of Tic-Tac-Toe Wish List to facilitate this. Each member was asked to make a tic-tac-toe grid. Alexandra declared that she did not know how to play the game. While expressing surprise, several of the girls explained it to her. I then instructed them to write in each space something that they wished was different in their home or neighborhood. Rosa said that she couldn't think of so many things. I explained that even though there were nine spaces, they could put the same thing in all the spaces if they wanted to. The group spent some time filling in the spaces, and several of the members helped each other and asked me how to spell various words. I then explained that they were to take turns stating one of the wishes that they put in their grids; other members were to cross off that box on their grids if they had a similar item. When tic-tac-toe was achieved, the winning members would be given a prize. I had brought in special candies to distribute to the winners. The wishes included living in a community without guns, wanting kids in school to be nice and not fight, and wanting a nicer place to live.

I let the members take turns telling what they had in their grids. I had to draw Josie out, as she was shy because of her limited language skills. As they went around, the girls continued to risk and self-disclose more. I continued to validate

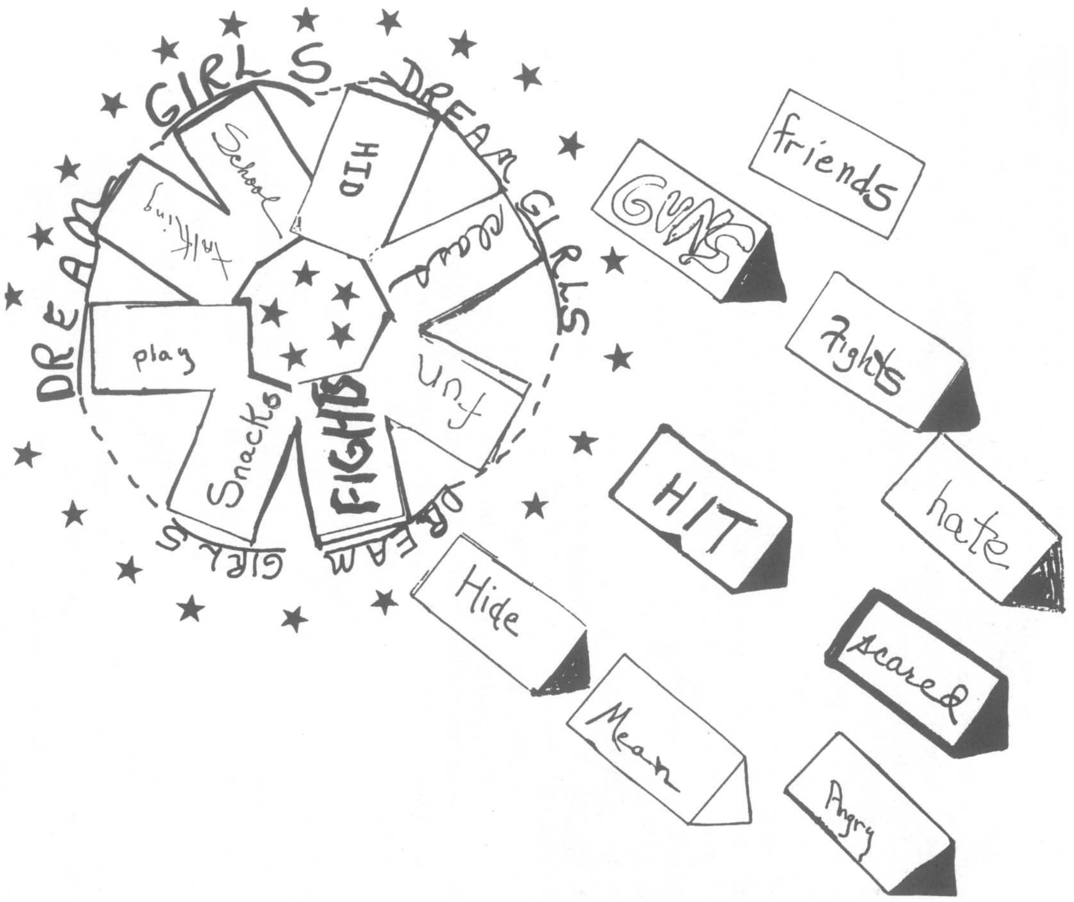

FIGURE 14.1. A collective poster with code words indicating the members' feelings about the group (at top left) and violence (at right).

their feelings while allowing the process to unfold naturally as the group continued to play and work. At the end of the game, I told the members that they were all "winners" and distributed the prizes evenly among them.

Sessions 8, 9, and 10

Sessions 8, 9, and 10 were representative of the late middle phase of group development. The group was cohesive. Issues of individuation and differentiation occurred. The girls were more in touch with their feelings. In session 8, they wrote a song around the theme "Let's make the world safe." This activity brought Kenyetta and Rosemarie together, since both had lovely voices. Alexandra and Kay were wonderful writers. The other girls provided rhythm and instrumentation.

Another critical incident from these three sessions involved an activity dealing with separating thoughts, feelings, and needs. I placed a large piece of brown paper on the floor with a rough sketch of a human being (see Figure 14.2). I then asked the group to think about what should go into each part, defining the head as thoughts, the heart as feelings, and the stomach as needs.

The group members focused on exploring differences among themselves, and I deliberately made minimal interventions. The members filled in the upper body with feelings and become somewhat silly in the needs area. They needed

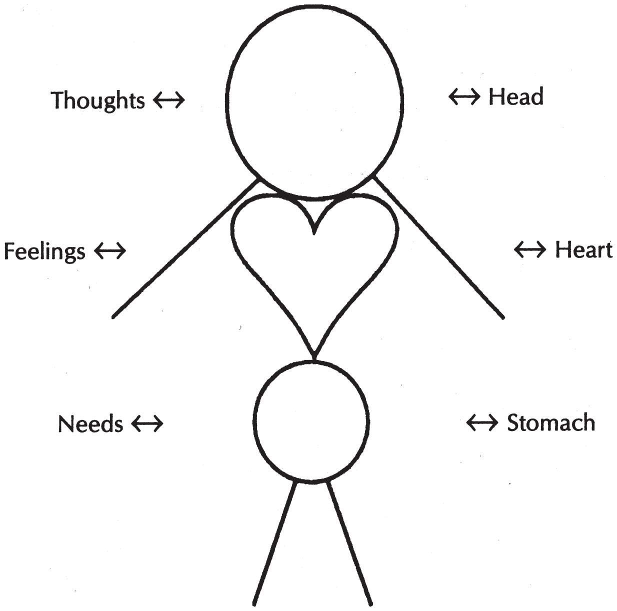

FIGURE 14.2. Outline of a human being, allowing space for thoughts (in the head), feelings (in the heart), and needs (in the stomach).

some help filling in the head with thoughts. During the process, however, the group experienced some intimate moments, and there was increased sharing.

Session 11

The focus of the final two sessions was on termination and endings. This was difficult, since the group had now developed into a fairly cohesive unit, where differences were verbalized and a sense of belonging was established. The members had learned how to establish mutual aid, how to make decisions, and how to solve problems. Many of the girls had found ways to use the group to fulfill their needs beyond the original purpose. For some of the members, it had become an opportunity to develop successful peer relationships.

Activities in sessions 11 and 12 included planning and having a party, writing a group poem, making goodbye cards, and taking and distributing a group photo. The group initially decided to make cards. I told them to write their names on a piece of paper. They put these in a bag, and each drew the name of a person she would make a card for. The members also planned a party. The girls refused to talk directly about the ending, but their feelings about one another and the group came out in the messages in the cards that they made and exchanged with one another. In fact, the messages became the group poem. At the end of the meeting, Rosa grabbed the leftover snacks as she left the room. Josie announced that she might not be able to come next week.

Session 12

The purpose of the last session of any group is to review the gains of the group, help members separate from each other, and provide them with a successful termination experience. The girls entered the room in a somewhat "hyper" state. One of the members brought a "boom box," announcing, "It is party time."

Content of Sessions	*Rationale/Analysis*
LEADER: Seems like everyone is in a good mood, and we are going to have a lot of time to party. However, I think that we need to cut the music for a few minutes to talk. Has anyone seen Josie?	The group's mood is regressive, and I need to set limits. The group's boundaries are beginning to disperse, and cohesion is breaking apart.
KENYETTA: We've done enough talking in this group.	Intimacy should not be encouraged in the final stage of group development.
LAURA: Josie's not here today.	I'm sorry to hear this.
KAY: Gee, I thought everyone would come today. It's special.	
LEADER: Yes, the group has been special,	I reaffirm the positive experience.

and it has been all of your hard work that has made it that way.	
(*The pizza arrives, and the girls get distracted from the talking. They want to eat and return to the discussion.*)	
LEADER: I wonder if each of you would mention one thing that you got from the group, and one thing that you did not get but would have liked to have gotten from the group.	I am making a demand for work.
ROSA: I don't see why the group has to end.	
LEADER: Rosa, it seems like you really like the group. Maybe you can share why you don't want the group to end.	I am reaching for the positives.
ROSA: I like the snacks and making stuff. And some of the girls are my friends now.	
ALEXANDRA: I liked meeting new girls. I never knew that people did violent things in America. I thought everything would be good here.	
ROSEMARIE: Yeah, mean things can happen anywhere.	
MARIA: Even in your own room.	
KAY: I didn't think that you had to be so careful here.	
KENYETTA: That's why you got to protect yourself.	She continues to feel vulnerable.
(*The members continue to discuss actualization of the group's purpose.*)	
LEADER: I think that we've found in the group that everyone protects themselves differently. One of the important things that happened here was that you were able to begin to talk about the bad things that you have seen.	
KENYETTA: Enough talk. Let's party.	Kenyetta continues to demonstrate her leadership abilities and oppositional behavior.
(*During the party period, the members talk about how sometimes they don't like each other. They also discussed the friendships they made in the group, and ask the leader whether she likes them.*)	

CONCLUSION

This chapter has provided an example of a time-limited latency-age children's group, formed to deal with the issues and concerns affecting children who witness violence. It is our belief that this type of intervention can help such children learn new ways of coping, provide a socialization experience, validate their experiences, and reduce some of their overt symptoms. It is a mechanism that can prevent more serious behavioral difficulties in the future.

Children such as the girls described here are all struggling with aggressive feelings, issues about their racial and ethnic identities, insufficient nurturance and stability at home, and feelings of inadequacy and sadness. A group leader needs to choose the points of intervention carefully. This group intervention alone cannot change a child's parental or neighborhood environment, or result in a total change in behavior. However, it can help such children feel less alone through the provision of successful peer relationships, a trusting relationship with an adult, and a safe place to begin sharing their anxieties and feelings in relation to the violence they have witnessed. It helps the children learn how to be safe while fulfilling important needs in a violent world (Lynn & Nisivoccia; 2005; Malekoff, 2004).

The chapter also demonstrates the use of activity as a means of facilitating the work of the group. The editor of this book might characterize the "activity" as "play" and the "work" as "therapy." One can see the interweaving of process and content, as well as the stages of group development. Ultimately, it is our hope that time-limited, purposeful group interventions such as this will be more frequently utilized in various practice settings.

Study Questions

1. Name several interventions that were critical to maintaining the group's purpose. How can a leader ensure that a group stays on track?
2. Discuss the issues of setting limits. How can a leader respond if members are openly defiant? Role-play this situation in a group with six members.
3. Discuss an issue that emerged but was not dealt with in the group described here. How would you have handled it?
4. Using this model of intervention, what other purposes or issues could a group like this deal with?
5. Discuss the pressures on a group leader of working with children who have witnessed violence. How can leaders deal with their own feelings about this?

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Chapter 15

School-Based Play Therapy and Solution-Oriented Brief Counseling for Children in Crisis

CASE OF MELINDA, AGE 6

Suzanne C. Griffith

The relationship between child and parents provides the building blocks for a child's lifelong development (Tronick, 1989). When it is well built, the relationship provides a sturdy foundation and resiliency for future challenges (Siegel, 1999). Even so, a child may run up against situations in which confusion and misunderstandings overwhelm his or her coping abilities, especially when the parents are also showing confusion (Vernon, 2004). When this confusion grows into anxiety and interferes with the child's willingness to attend school, the school counselor may be brought in as a first line of intervention.

This chapter discusses the use of solution-oriented brief counseling (SOBC) in helping children in crisis, with special attention to those aspects of SOBC that make it especially compatible with play therapy. The efficacy of this combined approach is demonstrated in a detailed case example.

The role of the school counselor changes in response to educational priorities and national standards (Gysbers, 2004). As all school staff members do, counselors have to fill many gaps and wear many hats. At the same time, children arrive at school with more varied experiences and needs than before (Amatea & Clark, 2005). Therapy, especially long-term therapy, has never been the role of the school counselor (Sklare, 2005). However, school counselors occupy a unique position that enables them to develop ongoing relationships with children, provide brief interventions when indicated, and then follow up in a manner that agency-based community practitioners may not (Galassi & Akos, 2004).

The case presented in this chapter involves a youngster who initially seemed to cope with her mother's serious illness, but whose situation later developed into a crisis following the deaths of other extended family members. These experiences escalated into high anxiety and school avoidance before the problem was brought to light and intervention was sought at school. Because of the child's age, play therapy was the preferred mode of relating. A solution-oriented intervention model (O'Hanlon & Weiner-Davis, 1989) was incorporated to empower the youngster to cope and to move forward both at home and at school.

BACKGROUND ON SOLUTION-FOCUSED/ SOLUTION-ORIENTED APPROACHES

Solution-Focused Brief Therapy

Solution-focused brief therapy (SFBT) has its foundation in three sources: the works of Milton Erickson, the Mental Research Institute (MRI) of California, and the Brief Therapy Family Center in Milwaukee, Wisconsin (de Shazer, 1985). Over the last four decades it has developed into a therapeutic approach with techniques that have been broadly adapted by cognitive-behavioral and narrative counselors and therapists (Sommers-Flannigan & Sommers-Flannigan, 2005). Initially utilized clinically with adults (Haley, 1973), SFBT has gained broader use with children (Berg & Steiner, 2003; Sklare, 2005) and in the schools (Metcalf, 1995; Murphy, 1997).

O'Hanlon and Weiner-Davis (1989) discuss Erickson's breaks with what were considered the traditional therapeutic approaches in the 1960s. An important distinction between SFBT and these traditional approaches is SFBT's lack of focus on "the problem," with the result that there is no lengthy intake procedure or assessment of the origins and development of the problem. Insight into the problem is not necessary, according to Erickson, who believed that complex issues do not require complex interventions or long-term therapy. Instead, Erickson encouraged a focus on the future and opportunities for change. Furthermore, he believed that the solutions should come from clients rather than the therapist, and that client-generated solutions have the best chance of succeeding (Haley, 1973).

MRI (Watzlawick, Weakland, & Fisch, 1974) has studied human behavior and problems in changing behavior since 1959. It applied many of Erickson's interactional ideas about resolving problems brought to psychotherapy. MRI encouraged the reframing of problems and creating change in patterns of interpersonal relating. To do this, it recommended focusing on the clients' language and perspectives and then using these to make connection and to formulate steps for change. The third MRI concept firmly adopted by SFBT is this sage advice: "If it works, do more; if it doesn't work, do something different."

Steve de Shazer spent time at both the Erickson Institute and MRI before creating the Brief Family Therapy Center, Milwaukee. There he and Insoo Kim Berg developed SFBT, describing it as incorporating a focus on the future, on solutions, and on a client's strengths rather than his or her deficiencies. The approach is pragmatic, focusing on what the client presents and on change (including the possibility that something has changed since the appointment was made). The therapist's questioning moves quickly to what the client sees as the desired goal or solution: asking specifically about what it will look like, how the client and others will know change has occurred, and what will be different. The phrasing the therapist uses is not "if change happens" but "when change happens," setting the expectation that a solution will be achieved. (Such presuppositions are similar to cognitive reframing.) de Shazer also probes for what seems to works now and when there are exceptions to the problem. Noting when the problem is not so bad or does not happen provides important information for both the client and therapist. Having clients focus on what works now, what ought not to change, and when the problem is not happening or is less severe puts the spotlight on the positive aspects of life and the exceptions to the problem. At the same time, the therapist notes the client's strengths—those client resources that may potentially help change the situation and are already within the client's behavioral repertoire. These are then drawn on for creating change.

Another approach that de Shazer (1985) introduced and that happens early in SFBT is the *externalization* of "the problem." Usually someone arrives at therapy already blamed for the problem. The therapist reframes the problem as something outside the client. This externalized issue is presented as sometimes being in control of the client/situation, but given the existence of exceptions, there are other times when the client is in control. The problem is seen not as a personal deficiency, but as something to consider together and to approach from several vantage points until appropriate solutions are found.

SFBT assumes that complex problems do not need complex solutions (de Shazer, 1985). Keeping it simple is a hallmark. Therapist and client together brainstorm what one small step the client might take, something he or she might try to do differently. One way to encourage small changes is the "scaling technique." The client is asked to rate feelings, behaviors, or experiences on a scale (usually 1 to 10), perhaps indicating where he or she is now and would like to be in the future, and together the therapist and client consider what steps the client can take right now. The therapist allies and consults with and respectfully cheerleads the client in considering the steps or in telling about the successes that begin from these small steps (De Jong & Berg, 2002).

Solution-Oriented Brief Counseling

Not focusing on the past and the problem does not have to mean ignoring the past either. Within SFBT there are differing views on how much time to give to discussion of the past and the problem. O'Hanlon and Weiner-Davis (1989) use the term "solution-oriented brief therapy" to connote a view that sufficient time ought to be given to the problem in order to connect with the client and understand the client's perspective, rather than moving so quickly to a focus on solutions. Because of my focus in this chapter on school counselors and their work, I use the term "solution-oriented brief counseling" (SOBC) hereafter. Given the importance of the counseling relationship (Lambert, 1992; Landreth, 2002; Rogers, 1958), it is critical that the counselor and client (in the school setting, the school counselor and student) make a good connection. Encouraging the client to tell his or her story gives the counselor time to hear the client's perspective, listen to the words used, and sense the client's world (Insight Media, 2003). This provides the counselor with insight concerning the client's role, level of motivation and strengths, and solutions already tried.

Application of SOBC and Play Therapy with Children

In working with a child, the counselor has to approach the relationship in terms of how the child and counselor work together developmentally, and to be aware of the child's limits, strengths, and sensitivities. Sometimes the child understands more than he or she can share verbally, and at other times the child appears to understand when he or she is really responding to nonverbal cues. Letting the child lead requires patience and careful listening, tracking, reflection, and encouragement. Play therapy (as described by Oaklander, 1988; Vernon, 2004; Webb, 1999; and various chapters in the present volume) allows the counselor a developmentally appropriate way to connect, to assess, and to build toward solutions. Encouraging the child to tell his or her story through play gives the therapist the opportunity to learn the child's perspective, listen to the words used, and see the situation through the child's eyes. This can provide insights as to the client's role, level of motivation and strengths, and solutions already tried before beginning SOBC.

School counselors have to shape their counseling to fit within the time constraints of school demands, making the SOBC approach particularly appropriate (Littrell & Zinck, 2004). Moreover, given their limited understanding of and experience with therapy, most children have few expectations that the problem will be the focus. They tend to have fewer resources for recalling the problem's origins and explaining their underlying cognitions and emotions. They are happy to make the future and solutions the focus of the therapeutic engagement, and, as counseling progresses, the counselor encourages that by not reinforcing talk about the problem (Berg & Steiner, 2003).

Play therapy rather than verbal discussion and analysis couples well with SOBC: Puppets can play out a problem and or a solution scenario; a baby dinosaur in the sandtray can be bullied and look for alternatives to fighting back; the members of a doll family can have a family meeting; parts of a picture of "the solution" can talk to each other as to what they will see happening after change happens. In playing and building solutions together for how to move forward or how to make his or her "world" less problematic, the child often simultaneously shows the counselor what is bothering him and what is encouraging his behaviors. Helping the child try out solutions through play gives further insights as to what he or she can handle and what is a good fit. The counselor needs to be careful not to solve the problem or come up with the solution for the child.

While meaning well, the counselor, in "doing for" the client, can rob the child of the opportunities for building needed competencies and feelings of self-efficacy.

A technique such as scaling is basic enough for a child to understand, and with the visual representation of the scale, client and counselor can mark small steps toward change. This is demonstrated in the case example below. Rather than suggesting homework, school counselors can suggest something fun, different, and humorous—such as "playing detective," or trying a "magic trick" or an experiment with a small change, and reporting back on the results (Littrell & Zinck, 2004). In short, the combination of SOBC and play therapy can provide the counselor an adaptable and upbeat way to connect with a troubled student, even a student in crisis.

THE CASE: MELINDA, AGE 6

In this case, play therapy and SOBC were combined to help a first-grade child regain regular school attendance, understand her mother's illness and the deaths of two close relatives, and gain a sense of personal control and authority. The therapist was an elementary school counselor with training in both approaches and extensive experience in working with children. (Names, occupations, and certain facts have been altered to protect confidentiality.)

Background Information

This case took place in a rural community and a school district composed of fewer than 500 students, with all classes in one K–12 building. Much of the background information was gathered through interviews with the mother after the problem with school attendance had started. The parents were in their middle to late 40s, with one child who was age 6 when the intervention started. The parents, Mr. and Mrs. Anderson, lived in town in their own home and were extensively involved in their church. The mother, Harriet, chose not to work outside the house following the birth of Melinda, and Robert, the father, was an independent electrician. Both parents had completed high school. The Andersons doted on their "miracle baby" and were protective of her.

The summer before Melinda's kindergarten year, her mother was diagnosed with breast cancer and received treatment at the regional center 60 miles away. She had chemotherapy and radiation, followed by excessive nausea and exhaustion after each treatment. Melinda was often home at these times, and also spent some time with her maternal grandparents and paternal uncle, who all lived locally. Melinda "understood" that her mom was sick and needed to rest a lot and see the doctor regularly, but she was not told about the seriousness of the mother's illness. The Andersons had hoped in this way to protect her.

Kindergarten in this district was conducted on a schedule alternating between 2 and 3 days a week, and Melinda's attendance was not made an issue.

She did well both socially and academically. However over the summer before first grade, both Melinda's paternal uncle and maternal grandfather died. Neither died of cancer, but both deaths were sudden and put a major strain on the family. Their church and community were supportive and involved. The child was with her mother all summer and did not appear upset, but, again, not much was discussed about either death.

As school approached, Melinda became clingy and whiny. She wanted to stay by her mother. She also started having nightmares, which were handled by allowing her to climb in bed with her parents. Moreover, first grade requires attendance all day every day, and Melinda did not want to attend school. Once school began, she complained of having stomachaches and wanted to stay home. At school, once her pains started, she would cry inconsolably. Mrs. Anderson was called to come get her, and sometimes she kept her home the next day, unsure of whether Melinda really was sick. This behavior was recognized as a real problem when it continued through week 2; Melinda was staying home and/or returning home more than she was in school. At the start of week 3, the school counselor, Mrs. Walsh, phoned the mother. Mrs. Anderson was relieved to be contacted and said she had been unsure how to proceed. It was arranged for the mother to meet with the counselor the next day, and to make a doctor's appointment to rule out any potential physical cause for the stomach pains. Mrs. Walsh also encouraged Mrs. Anderson to discuss with Melinda why she was coming to school to see her and why Melinda needed the doctor's appointment.

Because all primary grades in this school receive classroom developmental guidance, the school counselor is known to the students. Mrs. Walsh made a point of going into Melinda's first-grade classroom later on Monday to interact with the students. She also spent time observing the children in an activity, walking among them, and greeting many of them individually, including Melinda.

On Tuesday, Mrs. Walsh greeted Mrs. Anderson and Melinda at the front door and walked with them to the first-grade classroom. Mrs. Anderson and the counselor then conferred, with the counselor taking the background information presented above. It was clear that the parents were concerned but unsure how to proceed. They had not known what was appropriate to tell Melinda about the mother's cancer treatments and the family deaths. The doctor's appointment was scheduled for the next day; assuming that no medical cause would be found, the mother and counselor agreed that Mrs. Walsh would meet with Melinda later that week, and that the office would call Mrs. Walsh rather than Mrs. Anderson when Melinda presented with stomach pains. With Mrs. Anderson's permission, Mrs. Walsh said that she would explain to the classroom teacher, Ms. Beecroft, what the plan was, so that she would still let Melinda leave the classroom when and if the complaining and crying went beyond the child's ability to cope. Mrs. Walsh suggested that the child appeared to have internalized some trauma, but was unable to express herself other than through her need for constant attachment proximity. Both agreed that this need was significantly interfering with Melinda's adjustment to and engagement in normal school activities. Mrs. Walsh also encouraged the mother to be firm with Melinda and to explain that attending school was her "job," just as her parents had their jobs. The teacher would do the same, and all would reinforce any improvements in staying in school, self-calming and coping, and engaging in school activities. They decided that issues surrounding nightmares and sleeping arrangements could be postponed until the school avoidance was resolved.

As expected, the doctor's examination turned up no obvious physical cause for the stomachaches and pains. The doctor also encouraged Melinda to follow through with her "school job." Mrs. Anderson called Mrs. Walsh with this news, and they made plans for Mrs. Walsh to meet with Melinda on Friday. The mother and Melinda would also have some fun after school to celebrate how well they were doing their "jobs" this week, if Melinda was in school Thursday and Friday.

On Friday Mrs. Anderson brought Melinda to school and was greeted by Mrs. Walsh, and plans for their after-school fun were discussed. Mrs. Walsh was scheduled to meet with Melinda right after lunch. (In the descriptions that follow, Mrs. Walsh is the "I."

Session 1

Before lunch I received a call from the office. Melinda was there crying and wanting to call home. I finished up in a developmental guidance class and came to the office. Melinda sat there crying, and I sat with her and helped her get some Kleenex. With some coaxing, she came to my office. We settled into my office; I turned down the lights and encouraged her to look around my room, even while she was crying.

Content of Session	*Rationale/Analysis*
COUNSELOR: We were going to meet after lunch, but this will work out fine. Will you join me for lunch here?	
MELINDA: (*Sits in an upholstered chair by counselor's desk and looks around the room. She begins to cry again.*)	
C: You do sound so sad, Melinda. The pains must really be hurting. Is that right? Show me where.	I don't try to stop her crying. I want to acknowledge her pain and to let her know that it is OK to cry here. I see her crying as a way to communicate.
M: (*Points at her stomach and cries louder.*) I want Mommy. (*Sobs*) I want to go home. (*Sobs*) I don't feel good. (*Sobs*) I want Mommy.	
C: How about we call Mommy at the end of our session and you can talk to her then? I want to introduce you to Cody first. (*Counselor pulls a stuffed bear from a nearby table.*) Cody is here just for my students who have stomachaches. He seems to make stomachaches and pains	I share control with her and accept her request. I then direct her attention so as to distract her and to encourage self-soothing.

get more "bear-able." See how his stomach has been hugged—he is all soft and squeezable there. (*Phone rings.*) Would you like to hug him while I take this phone call?	While not planned, the phone call allows me to turn away from Melinda and see what she may do. The call lasts only a minute, but it is long enough for the child to hug the bear and comfort herself.
M: (*Takes bear tentatively and then more firmly.*)	
C: (*After the phone call ends*) Lots of students love to play with the dollhouse, and the play school too. Would you like to? No? Anything else?	Melinda shakes her head no, but I note that the tears have stopped.
(*There is a knock on the door. Melinda's teacher, Ms. Beecroft, opens the door and looks in.*)	
TEACHER: Here you are. Want to come to lunch with us?	
M: (*Looks at counselor and shakes her head.*)	
C: (*To teacher*) Would you bring us both a little lunch? I think we'll have a little lunch party here—me, Melinda, and Cody. Melinda, how about we set the table for lunch? Do you know how?	After the teacher returns with lunch, Melinda moves Cody to his own seat. I let Melinda have control, and she turns it into imaginary play. By talking about how much she helps her mom, I gain insight into the relationship.
(*Counselor gets out a box of plastic plates, cups, and utensils. The two talk about how Melinda helps her mom at home. This seems to make her more animated during the lunch party.*)	
(*Following lunch, counselor brings out a set of cards depicting people of different ages, sizes, ethnicities, and occupations, as well as various places and animals.*)	I choose a relaxed assessment approach. This set of cards (Ekbom, 2002) is an assessment method that I frequently use with children.
C: Melinda, I'd like you to look through these cards and pick out the ones most like your family.	I am purposefully vague; I want to see if she will bring up her grandparents on either side or her recently deceased uncle.
M: You mean like my mom and dad?	
C: And you too. Who else is in your family?	
M: There is Skippy, our dog.	
C: Anyone else?	
M: (*Shakes her head no and begins to sort through the cards, taking her time.*) This	She seems not ready for that yet.

one is kind of like Daddy, only his hat is green and he carries a tool box.	
C: How else is he like your daddy?	
M: Daddy smiles a lot too. . . . (*Sighs*) He used to smile a lot. Now he wears a sad face.	
C: Wears a sad face? (*Melinda does not respond, but keeps looking slowly through the cards.*) I suppose he has been sad since Uncle Nick died? (*She looks up at counselor.*) Your mother told me; she said that both your Uncle Nick and Grandpa Joe died this past summer. That can make smiling pretty difficult.	I want her to know that it is OK to talk about these things with me. But I do not expect her to say more just yet.
M: (*Gives a little gasp and takes out a new card. The card pictures a woman with a shaved head. Counselor gives her a quizzical look.*) This looks like Mommy when she lost all her hair. Not last summer, but before.	
C: This picture reminds you of that?	This is new information for me. The picture is evidently bringing this back, and with it some strong feelings. I want to reflect her emotions.
M: (*Nods and bites her lip.*) It was scary. Mommy looked so . . . not the same, not like Mommy.	
C: That sounds *really scary*.	
M: It just kind of started to fall out. Bunches. Dropping. . . . She looked so different. . . .	She seems to be recalling specific incidents.
C: Seems like you still remember just how it happened, and all those scary feelings come back—and maybe some confusing feelings?	I keep my voice tentative, so that she has room to confirm or change my understanding.
M: (*Looks up at counselor, her eyes filling with tears.*) Who is going to take care of Mommy while I am here? I need to be home with Mommy. I am her little nurse, and I help her feel better. (*At this point the tears spill down her cheeks.*) What if she dies while I am at school?	Here is the missing information: Melinda believes she needs to be at home to help her mother and keep her from dying. Perhaps this fear is a response to the deaths of her two close relatives.
C: (*Reaches out to Melinda and puts a hand on her arm.*) This sounds like a very real fear for you, Melinda. How very brave of you to come to school when you have these fears. (*Sits with her quietly.*) When you get all worried about your mom, do you get knots in your stomach?	I have to restrain my desire to say that all is going well with her mom. I am sure that she hears this plenty and that it is not alleviating her fears.
M: (*Looks at counselor for a moment, puts her hands on her stomach, and nods.*) Right here.	

C: And do they get very tight, like a big knot, and squeeze tighter?	Objectifying the fears.
M: They make me cry they hurt so much. And then I need Mommy to hold me before they will go away.	
C. That sounds like a really awful knot, or even a group of knots! (*Remains with a hand on Melinda's arm, making contact, and then proceeds softly.*) Melinda, when do you *not* have the hurting knots? When is the pain less?	I want Melinda to know that I really sense how she feels. However, while being respectful of her pain, I also want to find exceptions to them and to move to scaling her fears so we might take steps to decrease them, help her relax, and eventually put them under her control.
M: When I am home I don't have them. (*Pauses and thinks some more.*) Sometimes in the morning before school I feel them, and sometimes at night.	
C: So sometimes at home you feel them, but mostly you don't. (*Reaches for some paper and draws a line with a 0 at the bottom and a 10 at the top.*) Do you know what I have here? What I am making is a scale, like a thermometer, only this one is for showing how much the knots are squeezing your stomach. So a 0 means absolutely *no* knots and no fears. And a 10 is when the knots are horrible and are in control, and your stomach *really* hurts. Now what are missing are all the numbers in between. Would you make these with me? (*Melinda colors in 1–9.*) Excellent! You got them all on. Now down here at the bottom I put: "No knots. No fears. Melinda is in charge." And up here at 10 I put: "Horrible stomachaches and pains. Knots in control." How about you put a sad face up here and a happy face down here? So what would a 5 be? (*Melinda draws a neutral-like face.*) And what does that feel like, in the middle?	I want to get her engaged with the scale to make it more meaningful. I suggest that Melinda fill in the rest of the numbers and then draw the faces.
M: (*Looks thoughtful.*) That would be when I feel like a tug of war going on in my tummy.	
C: A tug of war?	
M: Yeah, like we had at school last year. I feel pulled both ways, and I don't know what to do.	She seems to have grasped the concept quickly. Making it concrete helps. (The school has a fair

C: Like one side says that it's OK to go to school or be in school, but the knots are also tugging and saying that maybe you ought to be home? (*Melinda nods. Counselor writes on the scale: "5 = Tug of war."*) And when do you feel that way? Can you tell me about some of these tug-of-war times?

M: Sometimes in class, like this morning.

C: How about when your mom brought you to school this morning? Where would that be on the scale? (*She points to below the 5, and counselor marks that a 4.*) And when you went to the office this morning, where would that be? (*She chooses a space between 7 and 8.*) So that was pretty bad this morning; the knots were in control. And where on the scale were the knots when I suggested we come to my office? (*She points to 5.*) So that was another tug-of-war time; you really were not sure what to do! And when you were squeezing Cody? Did those knots relax a little? So maybe a 4? (*She nods.*) And where are you now? (*She points to about a 3.*) So right now Melinda is controlling her fears and is winning that tug of war. This has been really excellent, Melinda. You have really helped me to understand what it has been like for you to come to school this fall. I am impressed with how well you have done. (*Melinda and counselor both smile.*) There is just a bit of the afternoon left before your mom will be here. Are you ready to return to your class?

M: You said I could call Mommy.

C: So I did.

day in the spring, and we have a tug of war.)

As she hesitates with reconstructing specific times, I consider suggesting times.

Melinda is watching carefully as we lay this out.

I watch her to see if there is any sense of guilt for not holding on to her worries, and am relieved to see that guilt does not seem to register.

Saying "I am impressed . . . " is sincere—a genuine compliment. It is also meant to build on her empowerment and self-efficacy.

I called Mrs. Anderson and put Melinda on the phone. She was upbeat with her mom, telling her first about her aches and then about Cody, our party, and the scale. As we returned to her classroom, I made it clear that she was free to tell her mom whatever parts of our time together she wanted to. I also took the opportunity to say that I thought her mom was looking pretty healthy these days.

I felt good about this first session and the connection we had made. I had also planted the notion that Melinda could self-soothe, and that her stomach pains could be scaled and possibly brought under her control. She could identify exceptions to the pains, not just at home but here at school. We would return to this, to her fears and confusion over her mother's illness, to the recent deaths, and to how she could cope with her fears.

Session 2

Because I wanted to keep the momentum going, I made a point of coming to Melinda's classroom Monday and mingling with the students. I asked Melinda how her time at the park (the after-school fun she had planned with her mother) had gone, and she gave me a big smile. We arranged to meet again for a lunch party. I asked her to see whether she could notice this morning when she was able to enjoy school and be below the 5, and when the knots were pulling the rope above the 5, and she could tell me about these at lunch. I made this request not to suppress discussion of the anxiety, but to give equal attention to the exceptions. I was ready for her at lunchtime, and we chatted over our sandwiches about the trip to the park before I began to ask about the scale.

Content of Session	*Rationale/Analysis*
COUNSELOR: Before we play, Melinda, I thought we could go back to the scale and what I asked you to be aware of this morning. Were you able to notice some times when you were above or below the 5 this morning?	I do mean to have the child initiate play, but since I asked her to notice the tugs, I need to follow up on this first.
MELINDA: My tummy didn't hurt when Ms. Beecroft was teaching us our new words. And the knots weren't there during recess.	I am glad to see that Melinda has taken note. If she had not come with specific examples, I would have assumed that the stomach pains had stayed at bay.
C: Excellent. What number should we give these times?	
M: A 2. No, a 3.	
C: So I will put those two here.	
M: I felt the tug of war start during reading.	
C: During reading?	
M: There was a story about a grandpa and grandson and a trip to the park. I started to miss Grandpa.	
C: So the story reminded you of Grandpa, and you felt the tug of war start? That was being quite aware, Melinda. And where shall we put that on the scale? How high?	I make a mental note that we will need to come back to these two deaths and to what I expect is a heightened aware-

Who was more in control of this tug-of-war rope? (*She sits a moment, staring at the scale.*) Did you need to go to the office? (*Melinda shakes her head no.*) Did you tell Ms. Beecroft? (*Again she shakes her head no.*) How did you manage that? You mean you felt the tug-of-war begin and you managed to stay in class?	ness now of her mother's potential death. It seems hard to give this a placement. My questions are meant to help clarify.
M: I guess I just did it. Ms Beecroft put us in groups to answer some questions, and I forgot about it. Bobby was really silly.	
C: Wow, Melinda, you definitely won that tug of war. Any other times this morning?	Again, I want to note the exceptions, cheerlead, and help her identify her own resources and strengths. She may have "forgotten" or been distracted, but I want her to see this as a choice.
M: After recess. I heard . . . Sarah talked about her mother being in bed, sick, and how she had to go stay with her cousins over the weekend.	
C: And . . . ? How did you cope with that time?	
M: (*Puts her hands on her stomach.*) I felt the knot, and I got all tight in here. I remember Mommy being sick.	Melinda's lip quivers. I see the tears in her eyes and hear fear in her voice. I am aware of how many daily events can bring up her fears, confusion, and the potential for loss.
C: Oh, my. All those fears came back and brought those knots with them. And yet . . . you still are here. Something must have happened?	
M: Ms. Beecroft asked us to take our milk to our desks, and when I got there I was going to say a silent grace, but I remembered Mommy saying everyone's prayers had helped her to get well. So I said a prayer for Sarah's mom and for my mommy, and I asked for both of them to get well.	This reminds me that Mrs. Anderson has mentioned how deeply involved in their church they are and how supportive their fellow parishioners were both summers. I recognize that Melinda's faith is another resource for her. An idea is taking shape for how we might put some of Melinda's coping practices on a list and put it in her desk as a reminder.
C: Melinda, that was such a fine idea to pray for both mommies. And it seems that you found *another* way to win the tug of war and stay in class. I hope you share this with your mom. Two times, wow! Can you think of anything else to add to this list today?	
M: (*Shakes her head.*) Can we do some more with the cards?	Melinda seems to feel comfortable enough to take charge.
C: Good idea. (*Reaches for the deck.*) So we have this one of your dad and this one of your mom.	

M: I want to find one for me and one for Skippy. (*Picks a policeman out for her dog and tells a couple of stories about his protecting her.*)	I wonder if letting the dog sleep with her might be a solution to her night fears.
C: Sounds like a *good* choice. And how about Melinda, which is a good card for you?	
M: (*Looks again.*) Here. This is the right one. I picked this nurse, 'cause I am Mommy's little nurse.	This is the second time she has mentioned this. I need to *not* dismiss it. This came up before, and I commented on how brave she was, and we talked about the tension and knots. I have not gotten back to her caretaking role, so she is taking me back to it. I wonder if we need a family meeting to discuss health issues. Being Mommy's helper is good, but I hope it need not interfere with her enjoying being a child and a student.
C: Sounds like that *is* an important role for you, Melinda. You must have been a big help to your mom back when she was sick. Tell me about this. (*Melinda describes several occasions when her mom was sick after her operation and she helped out.*) And *now* you help her out around the house, and the two of you play together and have fun. You have many roles, so maybe you need two cards. What do you think?	
M: (*Seems to like this idea, and finds a picture of a girl swinging.*) This can be me when I am playing and just being a kid.	
C: Great choice. You are teaching me so much. (*Melinda and counselor put the cards away.*) Would you be up for continuing to be a detective and keeping track of when you are winning the tug of war and we can meet again later this week? How are you feeling right now?	
M: A 3. (*Smiles. Counselor walks with her to her class and goes on to another classroom.*)	Children like this shorthand way of telegraphing their feelings.

Again the session went well, I thought. My developing hypothesis was that in the school year following her mother's operation and therapy, Melinda had been home enough, due to the kindergarten schedule, not to be so anxious and troubled over her mom. Developmentally, she may have grasped that this was a serious illness, but death had not been part of her reality. A year later, the two deaths over the summer had changed this, and she had a sense that people can die—and die suddenly. She hoped that by being at home, she could save her mom from a similar fate.

I was also impressed that Melinda could utilize scaling and was finding her inner resources. That morning she had made it through two experiences that previously might have caused her to tense up, cry, and leave the classroom (and maybe even school). Both times she had become distracted and let go of the anxiety; yet this was really a choice she had made, consciously or not, and this was progress.

I did not get back to Melinda on Tuesday, and on Wednesday the office called me to say that Melinda was absent. I called Mrs. Anderson, who told me that Melinda had had nightmares and they had all slept badly, so she let Melinda stay home. I asked whether anything might have happened to trigger the upset. She hesitated and then said that her mother had been over for dinner and had seemed a bit sad. Did I think that this might have caused it? Hard to tell, I told her, but I suggested that they visit the library for some books on death and loss. I mentioned a few I use here at school. I also asked what they thought of letting Skippy sleep with Melinda for now, as she seemed to see him as a good protector. Mrs. Anderson said she would talk with her husband about that.

I met with Melinda Thursday for our third session and suggested that she select some dolls or animals to play with. She went straight to the horses. It turned out that she had a great love of horses. She created an extended family of horses and got down to play with setting up a horse ranch. As she did, I learned that she had her own collection of horses, and her mom had said that some day she would be able to have riding lessons. I said that this would be an excellent activity for her. (I have watched many children conquer challenges after learning to control a horse; the ability to master riding such a large animal seems to build confidence.) The main members of the horse family mirrored her own; the filly and mare were inseparable. We talked briefly about how Melinda was managing "the knots" when she was at school. I learned that another Friday outing had been planned, this one to the library.

In the fourth session (the beginning of week 5 at school), Melinda played with the horses again, and this time as she played I reflected on the dramas she played out. She had two different scenes that she repeated in various ways: In one she rescued the mother horse from danger and attended to her, and in the second a variety of other problems faced the horse family and required finding solutions. During the first scene, I made comments as I tracked the actions and the emotions, taking cues from her dialogue and commentary. This way I provided a second commentary on the emotional underpinnings. During the second scene, I also pointed out the resourcefulness and resilience of the young filly and her growing competence.

It was during the fifth session that I was able to bring in what is referred to as the "miracle question." Although this question is often attributed to SFBT it has its roots in Adlerian therapy (Day, 2004) and was also used by Milton Erickson (Haley, 1973). It is often a useful technique to clarify the client's goal for counseling. Melinda had come in and was once again preparing to play with the horse family.

Content of Session	*Rationale/Analysis*
COUNSELOR: Melinda, let me interrupt you a minute before you start. I'd like you to imagine what would happen if while the	I choose not to phrase this as "a miracle" but as "something magical," because of the

horse family slept last night, something magical happened, and because they were asleep they didn't know that this magical thing happened. This magic solved the problems that have been upsetting the family. When you wake them up this morning, what will be the clues that might tip you and them off that something very special has happened? What will be different?	family's religious views and because belief in magic is age-appropriate. The miracle question is usually directed to the person: "How would you know and what would you do?"
MELINDA: (*Her eyes widen as she tries to imagine this.*) Something magical? Hmm.	
C: You can let the horses play this out, or you can tell me, or both. What will be different for this family, and how will they know it?	
M: Everyone will be happy and healthy?	Sometimes children give impossible scenarios, but these can still lead to uncovering what is missing or wanted that can be worked on.
C: And what will they do that tells you that they are happier and healthier? How will the family play today?	
M: (*Arranges the horses. The parent horses go into the field, and the filly prances over. The three gallop around together. Then the stallion takes off, and the filly and mare go back to the barn. Melinda gets up and retrieves a dog from the box and adds him to the group. Then she goes back into the box and pulls out another filly.*) This is her friend, and the two of them are going to play, 'cause the mama horse has to go see the grandma horse, and those two (*she puts the two mares together*) . . . both of them will be healthy and will laugh together, and Skippy—no, I mean . . . Pluto, this is Pluto, is going to play with the two girls, the two fillies, and he will bark really loud if there is any danger.	I really am not sure at this time if Melinda will be able to project onto the horses or if she will move back into talking about her family. Either way would be fine with me. I assume that the dog is Skippy joining the family. Melinda has mentioned to me previously that Skippy now sleeps in her room. A playmate is added, and this seems like a healthy sign too.
C: So one thing that is different is that the horse family feels healthy, and they have a dog who is a protector, and the filly plays with a friend? And how do we know they are healthy?	I bring her back to being more concrete about what this will look like or sound like.
M: The mommy horse doesn't go to the horse doctor, and the granny horse and mommy horse laugh a lot and do things together, and when the daddy horse comes home at lunch, he laughs too.	Melinda seems to have a picture in her head of the scene, whether from the past or how she wants it to be.

C: There will be laughter, and the grownups will have fun. And the filly? How is she different? How does the magic affect her?

M: Well, she doesn't have any stomachaches, and she goes to school and plays with her friends, and she doesn't have any bad dreams. (*Pause*) Do horses have bad dreams?

Children at this age often go back and forth between projection and reality.

C: I don't know. I assume they dream, and so maybe they can have scary dreams.

M: Well, if this filly has scary dreams, Pluto will chase them away.

C: Will the filly worry about the mommy horse?

M: No. 'Cause the filly will know that she is better.

C: And will the filly miss the mommy horse if she is off with the granny?

M: No, 'cause she will be with her own friends. (*Turns and gets back to playing.*)

In the sessions that followed, certain changes were made. First, I encouraged Melinda to bring a school friend with her for lunch once a week, and the two could play horses or other things. During our one-on-one sessions (which dropped in frequency), we noted the decrease in times when the aches tugged on her; we counted the days and then weeks of full school attendance; and we focused on her coping and improvements. We had one meeting with Mrs. Anderson in week 7, where Melinda shared her 0–10 scale, exhibited the list of coping steps she could take to keep the knots from pulling too hard, and displayed her horse family. I encouraged Mrs. Anderson to consider riding lessons for Melinda, even at this age. With Melinda in the room, I also asked Mrs. Anderson about her health and had her clarify for me how her recovery was going. I also asked how her own mother and her husband were doing, given all the stress the family had been under. I learned that all were doing better. When I encouraged them to plan some fun family outings, I learned that plans were already in the works.

Melinda continued to come for lunch with various friends once a week for another month or so, but even this tapered off. During our occasional one-on-one session, I followed up on what Mrs. Anderson had begun with some readings and drawings on illness and death, and helped her process these at her developmental level. I stopped seeing Melinda for these meetings before the winter break.

Melinda did come and tell me when her horse-riding lessons began the next semester. I saw her often in her classroom, in the halls, and in the lunchroom, and sometimes we would wave or chat. I left that up to her. I did not receive any more calls from the office about Melinda's needing to go home. In second grade, the next year, two other students lost family members. I wondered if this might raise Melinda's anxieties, but the general interventions on issues of death and loss that we did in the classrooms seemed to be enough for her. In the summer between Melinda's first- and second-grade years, I had the opportunity to see Melinda riding a horse. I was greatly impressed to see this small child capably managing a large horse and riding him around a ring. The Andersons were very proud and very happy, and so was I.

CONCLUDING COMMENTS

Because the time for therapeutic interventions in the schools is limited, school counselors must be resourceful. Play therapy provides a window into a child's reality. When combined with SOBC, as with Melinda, it is possible to move the therapeutic process forward in several specific areas. In this case, my first goal was to increase Melinda's attendance and ability to participate actively in school. To do this I needed first to understand what lay behind the stomachaches. I was sure that these were her attempts to communicate her distress and confusion, but it was not clear that she understood her emotions. As part of this discovery process, we were able to use scaling and externalizing techniques, which allowed Melinda and me a way to understand what was happening. Melinda's metaphor of a tug-of-war rope let me use her language; it gave us a tool for understanding her situation and for countering her distress. The thermometer scale provided a concrete image of what was going on, and also focused on how she was successful at not letting the tug-of-war rope create the big knots in her stomach. Once the stomachaches were given meaning, a second goal was for Melinda to gain sufficient understanding of her mother's illness and recovery, and of how her mother's situation differed from what had happened to her uncle and grandpa, that she could become less confused and frightened. To do this, it was important for her parents (especially her mother) to become more comfortable with talking with Melinda about these things rather than trying to protect her from them. As her mother gained confidence that she could do this at an appropriate developmental level, with the assistance of books for elementary students, Melinda was able to relax. The "miracle question" helped both Melinda and I to see what the long-term goal of our time together ought to be. In this case, Melinda chose the horses for her symbolic play. While she used this family initially to play out her trauma, once we had discussed the miracle, her horse family moved in that direction almost instantaneously.

SOBC and play therapy have been successfully applied together in schools to several other types of crises, including family illness, moving, imprisonment of a parent, military deployment for war, and home burglary and house fires. In each case the various play techniques have been combined with a solution-oriented approach that builds on the child's resources, language, exceptions, and images of the desired future.

The open-door policy of the school counselor and the children's access to the counselor may mean that if problems arise, the children feel comfortable returning. The counselor's focus on the children's resources and the exceptions to the problem seems to provide a boost to their resiliency in the face of future adversities. One of the satisfactions of being a school counselor is being able to watch children, such as Melinda, grow up and capably handle new challenges.

Study Questions

1. Discuss the advantages and disadvantages of handling this case in school rather than referring it out. Given that Mrs. Walsh met with Melinda over 20 times (one-on-one, with her mother, and with a school friend), does the frequency change the benefits of in-school counseling? For a referral out in this case, who ought to have been the client or clients, and what would have been the appropriate focus of the therapy?
2. It is not unusual for parents, due to their own discomfort with certain topics such as death, dying, and major illnesses, to avoid discussing these with their children. Discuss how you might have consulted with Mrs. Anderson on ways that she could approach Melinda at age 5 and/or age 6 about these real issues.
3. If the deaths among classmates' families the next year had caused Melinda to regress, what might Mrs. Walsh do to help Melinda this time? Consider possible combinations of play therapy and SOBC.
4. Discuss the pros and cons of skipping (or skimming) an exploration of the past and moving fairly quickly to exceptions and solutions early in therapy. Consider these ideas for clients at different ages: a 6-year-old, a 16-year-old, and a 36-year-old. Why would (or should) the ages alter your coverage of past events?

Role-Play Exercises

1. Working in dyads, consider a present problem that is bogging you down. Present it to your partner. Your partner can then ask you the miracle question: "If you went to bed tonight, and during the night a miracle happened but you did not know it, what would be different in the morning because of this? What would you notice?" Your partner should keep you focused on concrete differences, as well as actual images of what would look different: "What would others notice as different?" Sometimes it helps to pretend that there is a video camera catching the difference in behaviors and to ask about what we would see on video that would be different. Following the role play, discuss how this question and the role play affected your thinking about your situation.

2. Another role play can take this same problem (above) and use scaling and exception questions. "On a scale of 1 to 10, where is the problem right now? When is it less of a problem? Tell me about these exceptions. Where on the scale would they go? When the problem is really bad, where on the scale has it been? How have you managed to move it to its present place? What is one small step you can do now—either something you have done before that has helped, or something that is new—to move you in a positive direction on this scale?" Following the role play, discuss what happened when you focused on exceptions and placed the situation on a continuum.

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Part IV

CRISES IN THE COMMUNITY AND WORLD

Chapter 16

International Interventions and Challenges Following the Crisis of Natural Disasters

Jennifer Baggerly

"Is the world coming to an end?" asked a terrified child whose mother and home were swept away by a tsunami in Southeast Asia. This question could have been asked by an estimated 1.5 million children who were displaced from their homes after the December 26, 2004 tsunami in the Southeast Asian countries of India, Indonesia, Sri Lanka, Thailand, and the Maldives (United Nations Children's Fund, 2005). The 2004 tsunami killed 225,841 people, affected 2,378,806 people, and caused over $7 billion in damage (Centre for Research on the Epidemiology of Disasters [CRED], 2005).

Natural disasters such as tsunamis, hurricanes, floods, earthquakes, and famines have increased by 56% throughout the world, from 1,735 disasters between 1994 and 1999 to 2,699 disasters between 2000 and 2005 (CRED, 2005). Natural disasters affected an average of 255 million people each year between 1994 and 2003, and killed an average of 58,000 people annually (Guha-Sapir, Hargitt, & Hoyors, 2004). "In the year 2003 one in 25 people worldwide were affected by a natural disaster" (Guha-Sapir et al., 2004, p. 7). Scientists predict that the number of natural disasters and people affected will increase further in the future, due to global climate changes, urbanization, and the inability of poor populations to escape (Guha-Sapir et al., 2004).

Mental health professionals must be prepared to mitigate the devastating impact of natural disasters on children worldwide (Baggerly, 2006). Indeed, it takes a village to raise a child. Yet it takes a global village to restore a child's psyche after a natural disaster. This is an issue of social justice that requires action. Ethically and professionally, mental health professionals have a responsibility to advocate for children in crisis throughout the world and to respond to crises whenever possible. The goal of this chapter is to prepare mental health professionals for international interventions following the crisis of natural disasters. Specifically, this chapter addresses (1) the impact of natural disasters on children, (2) ways to prepare for disaster response deployment, (3) interventions that play therapists provided for children after the 2004 tsunami in Sri Lanka, and (4) challenges that the therapists experienced. The chapter is based on research and my experience on the Association for Play Therapy (APT)/Operation USA children's tsunami intervention team that was deployed in February 2005 to Sri Lanka.

IMPACT OF NATURAL DISASTERS ON CHILDREN'S DEVELOPMENT

In the northeastern part of Sri Lanka, an island country off the southern tip of India, over 75 Tamil children orphaned by the civil war sat in an American-funded chapel listening to the pastor and orphanage director preach. The date was December 26, 2004. Suddenly they saw a large wave of water rising out of the sea 50 yards away. The children and staff ran for the hills. They slept in school buses for 3 days while debris was cleared from their orphanage. Just miles down the coastline, numerous Tamil families worshiped at the Hindu temple or performed their daily routines of washing and fishing. Suddenly they were engulfed in a tidal wave and struggled to survive as the water ripped away their clothes and children. Many women refused to run when the second wave came, because their saris were ripped off by the water and it is culturally shameful to be naked in public, so they remained covered by the water and eventually drowned. In the southern part of Sri Lanka, Sinhalese families, Buddhist monks, and tourists walking near the beach were also engulfed in a tidal wave. Children watched their parents drown as they tried to rescue other siblings. The power of the water did not discriminate in destroying hotels, schools, and thatch houses. What impact did this devastating tsunami have on the children? Although they each had a unique individual response, research reveals some general responses in the areas of neurophysiology, development, typical symptoms, and clinical symptoms.

Trauma from natural disasters can affect children's neurophysiological systems in ways that cause changes in their behavior, cognitive functioning, mental health, and physical development (Perry, Pollard, Blakely, Baker, & Vigilante, 1995; Solomon & Heide, 2005; Vernberg, La Greca, Silverman, & Prinstein, 1996). Natural disasters and their aftermath create threats that overwhelm children's typical coping strategies. These threats (both real and perceived) activate the sympathetic–adrenal system, which mobilizes the "fight-or-flight" response of increased breathing and heart rate. Ongoing threats or trauma reminders can cause the fight-or-flight mechanism to become stuck in continuous looping, causing hyperarousal, irritability, and sleeplessness; smaller intracranial and cerebral volumes; limited explicit memory; and a diminished sense of identity (Kagan, 2004). Memories from a disaster may become dysfunctionally stored in the right limbic system and produce "flashbacks"—that is, intrusive images, thoughts, smells, and sounds of the terrifying event (Solomon & Heide, 2005). Children may avoid trauma reminders, such as places, people, or things associated with the event (e.g., school classrooms, teachers, or water), in an attempt to control their hyperarousal and flashbacks.

Natural disasters that disrupt relationships between infants and their primary caregivers can hinder children's brain development in the prefrontal cortex (i.e., the orbitofrontal cortex and anterior cingulate cortex) and limbic system, and the neural circuits that connect them. Some of these neural circuits are important in psychological, emotional, and physiological development. When these neural structures and pathways are compromised, the future development of empathy and moral judgment can be adversely affected (Solomon & Heide, 2005). Diminished emotional development along with increased hyperarousal (due to effects on the limbic and endocrine systems) may contribute to increased violence, such as fighting during early years or possibly involvement in terrorism or war during later years.

Natural disasters create serious setbacks in the developmental processes of a community, as well as of its children (Guha-Sapir et al., 2004, p. 13). When a community's economic base is disrupted by natural disasters, finances are redirected toward rebuilding rather than toward long-term development of a sustainable community-directed financial infrastructure that funds nutrition and education. Even with the help of relief organizations, many children will experience malnutrition that stunts their physical development. For example, after the 1997 natural disasters in the Democratic People's Republic of North Korea, acute malnutrition (wasting) affected up to 32% of young children, while chronic malnutrition (stunting) affected up to 74% of children (Katona-Apte & Mokdad, 1998). Traumatic experiences can also change children's metabolism, resulting in diminished immune system functions that make them more susceptible to disease (Solomon & Heide, 2005). For example, after the 2004 Asian tsunami killed 70% of the population in Aceh Jaya District, Indonesia, survivors suffered from a lack of sanitation and clean water. Over 85% of children under the age of 5 experienced diarrhea, which was the leading cause of morbidity after the tsunami (Brennan & Rimba, 2005).

TYPICAL SYMPTOMS

Children's typical symptoms after natural disasters include fear, depression, self-blame, guilt, loss of interest in school and other activities, regressive behavior, sleep and appetite disturbance, night terrors, aggressiveness, poor concentration, and separation anxiety (Speier, 2000). Shioyama et al. (2000) studied 9,000 third-, fifth-, and eighth-grade Japanese children affected by the Great Hanshin-Awaji Earthquake. They found that children's symptoms factored into three broad categories of (1) fear and anxiety, which peaked 4 months after the disaster and decreased as time passed; (2) depression and psychophysical symptoms, which peaked at 6 months and decreased after a year; and (3) prosocial tendencies.

Symptoms vary from minimum to severe, based on a child's developmental level, personal experiences, and emotional/physical health, as well as the responses of parents to the incident (Vogel & Vernberg, 1993). For preschool children, typical symptoms include the following: nonverbal fears, expressed in constant crying or whimpering and excessive clinging; nightmares or night terrors; and regressive behavior such as thumb sucking or bedwetting (Speier, 2000). For elementary-school-age children, typical symptoms include the following: fear of danger to self and loved ones; increased fighting, hyperactivity, and inattentiveness; withdrawal from friends; school refusal; and reenactment through traumatic play (Speier, 2000). Typical symptoms of preadolescence and adolescence include physical complaints of headache or stomachache; withdrawal; antisocial behavior of stealing or acting out; school problems; risk-taking behaviors; and drug and alcohol problems (Speier, 2000). Usually these typical symptoms last only a short time. However, if they continue past 30 days after the resolution of the event, professional counseling may be needed.

The differences between young children's and older children's symptoms can be primarily attributed to their cognitive-developmental levels. Since younger children have not developed cognitive permanence, they believe that loss can be undone, and thus have a difficult time understanding the consequences of natural disasters (Charkow, 1998). In addition, younger children's magical thinking may cause them to believe that their thoughts contributed to or even caused the disaster (Charkow, 1998). Although very young children under are unable to understand the permanence of loss, they are aware of disruptions in their routines. They are also perceptively aware of their parents' distress after a disaster (Norris-Shortle, Young, & Williams, 1993). Some of their regressive and clinging behavior is an attempt to keep caring adults near them and away from harm (National Institute of Mental Health [NIMH], 2001).

CLINICAL SYMPTOMS

Although many children will recover from these typical symptoms with basic support after a natural disaster, some children experience ongoing symptoms because of their beliefs about who or what caused the event, preexisting mental health problems, lack of community support, parents' absence during the event, and/or significant adults' negative reactions (Speier, 2000). Vernberg et al. (1996) found that 55% of elementary school children in their study exhibited moderate to very severe symptoms 3 months after Hurricane Andrew. McDermott, Lee, Judd, and Gibbon (2005) found that 22.6% of children in their study had abnormally high emotional symptoms 6 months after exposure to a wildfire disaster.

Children's clinical symptoms may result in a diagnosis of acute stress disorder (ASD), posttraumatic stress disorder (PTSD), other anxiety disorders, or depressive disorders. Indicators of childhood PTSD include the following groups of symptoms that persist longer than 30 days after exposure to a traumatic event: (1) persistent reexperiencing of the event through intrusive memories, frightening dreams (with or without recognizable content), and/or repetitive play in which themes or aspect of the disaster are expressed; (2) avoidance of things related to the disaster; and (3) increased arousal, such as irritability or difficulty concentrating (American Psychiatric Association, 2000). These three PTSD symptom clusters (intrusion/active avoidance, numbing/passive avoidance, and arousal) in children were confirmed by Anthony, Lonigan, and Hecht's (1999) study of 5,664 child and adolescent victims of Hurricane Hugo.

Rates of PTSD in children after natural disasters vary, based on the event and criteria used for the study. For example, 4 months after Typhoon Rusa devastated rural areas in South Korea, 12.3% of elementary school children had either moderate or severe PTSD symptoms, 22.7% had mild symptoms, and 65% had subclinical symptoms (Lee, Ha, Kim, & Kwon, 2004). Yet researchers (Shaw, Applegate, & Schorr, 1996) studying children ages 7–13 who experienced Hurricane Andrew in 1992 found that 70% of their subjects reported moderate to severe PTSD symptoms 21 months after the hurricane. Similarly, Russoniello et al. (2002) found that 6 months after Hurricane Floyd devastated North Carolina, 71% of fourth-grade children had either moderate or severe PTSD symptoms, while 24% had mild symptoms. However, in a study of 5,687 elementary school children affected by Hurricane Hugo, only 5.5% actually met diagnostic criteria for PTSD (Lonigan, Anthony, & Shannon, 1998). Rates of PTSD in Sri Lankan children after the 2004 tsunami have not yet been published.

Vernberg et al.'s (1996) research of elementary school children after Hurricane Andrew found that children's development of PTSD was influenced by the following five factors:

- Exposure to traumatic events during and after the disaster
- Preexisting demographic characteristics
- Occurrence of major life stressors
- Availability of social support
- Type of coping strategies used to manage disaster-related stress

These researchers also found that children's symptoms persisted due to interactions between daily life hassles and the severity of the disaster; stressful life events, such as parental divorce or loss of employment; and loss of support from overburdened community systems and schools (Speier, 2000). McDermott et al. (2005) found that younger children and children with higher levels of exposure and threat had a higher prevalence of PTSD than older children and children with lower levels of exposure and threat. Despite these findings, it is important to note that after Belter and Shannon (1993) reviewed the literature, they concluded that "diagnosable psychopathology is not commonly seen in the great majority of children who experience a natural disaster" (p. 99).

DISASTER INTERVENTION WITH CHILDREN

Evidence Base

It is important to identify evidence-based disaster interventions with children. Disaster intervention training has been shown to prepare public health and mental health professionals to intervene appropriately after natural disasters (Reid et al., 2005). Children receiving individual and group psychosocial interventions from school-based counselors 2 years after Hurricane Iniki had significant decreases in trauma symptoms, compared to those of control groups (Chemtob, Nakashima, & Hamada, 2002). Children's adaptive functioning was shown to increase significantly, compared to the functioning of control groups, after teacher-mediated interventions in response to earthquakes in Turkey (Wolmer, Laor, Dedeoglu, Siev, & Yazgan, 2005). Children who received play therapy after the 1999 earthquake in Taiwan showed significant decreases in their anxiety and suicide risk, compared to that of control groups (Shen, 2002). Thus far, cognitive-behavioral therapy has been espoused as the best-validated treatment for children who experience traumatic symptoms (Cohen, Deblinger, & Mannarino, 2006). However, research is still needed to determine which disaster intervention protocols are most effective in decreasing children's symptoms after natural disasters. The APT Sri Lanka children's tsunami intervention team used evidence-informed disaster response principles and interventions. These principles and interventions are discussed below.

Principles and Preparation

As a disaster-preparedness instructor and a member of the APT Sri Lanka team, I prepared myself for deployment by observing eight principles. The first principle in disaster response is to follow "incident command structures," which are paramilitary methods of establishing order in chaos (Federal Emergency Management Agency, 2003). The incident command structure determines who goes where to do a particular job. Mental health professionals should go to a disaster site only if they are deployed to a specific place by an official representative of a government agency or a registered nongovernment organization (NGO), such as the International Red Cross, Save the Children, EMDR Humanitarian Assistance Programs, or the like. The APT team was deployed to specific areas in Sri Lanka by Operation USA, an NGO that has provided disaster relief in Sri Lanka for almost two decades.

The second principle is to understand the differing objectives for the five phases of a disaster (NIMH, 2002). During the "preincident phase," the objectives are community preparation and improvement of coping strategies. The mental health professional's role includes training, collaboration, informing policy, and setting structure for rapid assistance. During the "impact phase," the objectives are survival and communication. The mental health professional's role emphasizes meeting basic needs of food, shelter, and safety; providing psychological first aid by supporting those who are most distressed; monitoring the environment for stressors; and providing consultation and training for caregivers. During the "rescue phase," the objective is adjustment. The mental health professional's role includes conducting needs assessment, triage, outreach, and information dissemination, as well as fostering resilience and recovery. During the "recovery phase," the goals are appraisal and planning. The mental health professional's role includes monitoring the recovery environment by listening to those most affected, observing ongoing threats, and monitoring services that are being provided. During the "return-to-life phase," the objective is reintegration. The mental health professional's role is to reduce symptoms and improve functioning via individual, family, and group psychotherapy.

In situations of international disaster response, mental health professionals are most likely to be deployed during the recovery phase. Interventions will need to be adjusted accordingly, through short-term approaches and referrals to community resources. Mental health professionals must not initiate psychological processes that cannot be contained and monitored. For example, prior to the tsunami, an unwitting therapist working with Sri Lankan children affected by their country's civil war asked them to write in journals about their most frightening events just a few days before she left the country. After she left, many children had nightmares and outbursts of crying, and there was no trained mental health professional to intervene. In contrast, APT team members' interventions focused on psychoeducation about normal symptoms and coping strategies, which will be described in detail later. We promoted children's resilience through play therapy techniques. However, we did *not* provide play therapy, because of our beliefs that this should be done by therapists residing in Sri Lanka who could provide long-term follow-up.

The third principle of disaster response is to maintain an expectation that children and their families will have a normal recovery. Rather than seeing all symptoms as pathological, mental health professionals should hold the view that most children are simply having normal responses to abnormal experiences. In Sri Lanka, normalizing children's responses seemed to fit well with the Buddhist belief of accepting suffering as part of life and gaining enlightenment from it. Normalizing responses also avoided the cultural stigma associated with mental health problems.

The fourth principle is to follow the "six C's" of disaster mental health (Mitchell & Everly, 2003; World Health Organization, 2003). Calmness is maintained by mental health professionals through deep breathing and positive self-talk. Common-sense reminders need to be offered to people who are panicking or disoriented. Compassion is expressed through reassuring words and simple acts of kindness. Collaboration is needed with all organizations, professionals, and families. Communication of children's needs and therapeutic procedures must be clearly stated to parents and professionals. Control of self is maintained by taking breaks as necessary, obtaining emotional support, and developing a "compassion fatigue" resiliency plan (Gentry, 2002; Gentry, Baranowsky, & Dunning, 2002).

The fifth principle for disaster response is to maintain hardiness and flexibility (NIMH, 2002). International disaster response requires physical hardiness for long days in uncomfortable settings. Professionals need to be healthy and strong to respond in a disaster. For example, one APT team in Sri Lanka rode in a van for 8 hours over bumpy roads, and another team slept on a concrete floor. Flexibility is essential for constantly changing situations where professionals are asked to "hurry up and wait," change their location, and do something different. Mental health professionals will also need to be flexible in order to be multiculturally competent. Our APT team was flexible in adapting spiritual coping strategies for Sinhalese Buddhists and Muslims, as well as Tamil Hindus and Christians.

The sixth principle for disaster response is to utilize developmentally appropriate approaches with children. Children are not miniature adults (Landreth, 2002). They must be respected by engaging them in their natural language of play. As Garry Landreth (2002) and others have said, "toys are children's words and play is their language" (p. 16). Children should be engaged with toys, puppets, art materials, and story books (Webb, 2002), and should be given plenty of opportunity to play. Our APT members gave balls, bubbles, puppets, crayons, and other play materials to teachers to share with children.

The last principle is to gather specific information on the country, the culture, and the natural disaster that occurred. This information is available at the Disaster Management and Humanitarian Assistance Toolkit (*www.hsc.usf.edu/nocms/publichealth/cdmha/toolkit_dm/Index_English.pdf*). Mental health professionals need accurate information on disasters to explain the nature of the event to children. Mental health professionals also need cultural information and orientation. APT members received an in-depth cultural orientation, including information on history, current politics, religion, customs, and death/funeral rituals, from native Sri Lankans. Consequently, differing interventions were tailored for Sinhalese children (who are primarily Buddhist) versus Tamil children (who are Hindu). For example, in our work with Buddhist children, references to "meditation" replaced "praying to gods." Other cultural practices included incorporating "orphans" into families of relatives and friends; respecting the custom that only close relatives hug children; and dressing with long pants, conservative shirts, and simple earrings (for women).

Awareness of the 20 years of armed conflict between the majority Sinhalese and the minority Tamils was essential in understanding the complex trauma of many Tamil children, who had witnessed violence throughout their lives (Chase et al., 1999). One Tamil leader explained that the tsunami seemed minimal compared to the violence (e.g., landmines, sexual assault, death of family members) that many of the Tamil children had previously experienced. A Tamil proverb states that if you are drowning, it doesn't matter if the water is 6 inches or 60 feet above your head. This knowledge helped APT members carefully monitor children's responses and advocate for services as needed.

Surveying the physical damage to towns may increase mental health professionals' understanding and empathy. Before meeting with children and parents, Operation USA members escorted APT members to view physical destruction. Concrete slabs marked the sites where homes once stood. Women's saris were wrapped around trees. Broken sandals and household items littered the beach. A Hindu temple was crumbled in the sand. Rows of makeshift white tents sheltered weary, hot families. Yet, in the midst of all this destruction, signs of resilience could be found. A father and his 9-year-old son lifted coconuts above their heads to show their strength. A statue of Ganesh, the elephant-headed god, and an incense burner were set up next to the destroyed Hindu temple, indicating that people still practiced their faith.

Interventions and Challenges

Working with Translators

Prior to beginning interventions, mental health professionals need to review cultural customs and therapeutic protocol with translators. In Sri Lanka, it was customary to have tea breaks at regularly scheduled times, even if an intervention was not complete. Reviewing the schedule with translators minimized disruptions at inopportune times. Intervention protocol and phrasing will also need to be reviewed to ensure cultural appropriateness. For example, one typical coping strategy in the United States is to hug friends. However, the Sri Lankan translator informed APT members that Tamil children only hug close family members. One challenge our team faced was hiring a translator who was familiar with psychological procedures. When APT members taught Sri Lankan children about relaxation, one translator was harsh and authoritative. Fortunately, we later found another translator who was gentle and encouraging.

Teacher and Parent Consultation

Prior to meeting with children, mental health professionals should consult with teachers and parents to assess the disaster's impact on children and to identify current needs. When our APT team asked how children were doing after the tsunami, Sri Lankan teachers shared children's drawings of people and objects floating in water. Figure 16.1 shows people stretching up their arms as they are totally surrounded by water—a common survival attempt as the tsunami swept people away. Another child drew people, boats, houses, and bombs floating in water, which revealed a concern about landmines that were swept up by the tsunami. One child drew pictures of children swimming past a smaller child face down in water mixed with mud. A sense of overwhelming despair was clear in their drawings.

Mental health professionals should address teachers' and parents' concerns directly, since their coping ability is a main determinant of how children will respond (Speier, 2000). If teachers and parents exhibit anxiety about certain issues, children are likely to mirror that anxiety. For example, consider the following dialogue that occurred between APT members and Sri Lankan teachers.

FIGURE 16.1. A drawing by a Sri Lankan child of people being swept away by the tsunami.

Content of Session	*Rationale/Analysis*
Play Therapist: I'm from Florida, and we had four hurricanes this year. I noticed that after the hurricanes, many children had nightmares, restlessness, and fear about future storms. These are usually normal responses. What did you notice in the children here after the tsunami?	An attempt to establish empathy with teachers concerning the impact of a natural disaster; an attempt to normalize children's symptoms after a natural disaster; and a question allowing for the possibilities of differences, honoring the teachers' observations, and assessing their perspective.
Teacher: Children talk to each other about another tsunami coming. Then they all get upset and are afraid to go aside to play. We are running out of things to do inside.	An example of mass sociogenic panic (also seen in U.S. children after the terrorist attacks of September 11, 2001), and a resulting need for practical teaching activities.
PT: You are worried and tired. The children's fears are typical after this scary situation. We know some ways to decrease children's anxiety.	Reflection and validation of feelings; normalizing of responses; and a suggestion offering hope and giving teachers the power of choice.

Would you like to learn? (*Interventions described later are taught.*)	
T: We told the children not to go to the beach because another tsunami might come. The children say they are worried about their fathers, who have to go to the beach to fish.	An example of how the teachers' anxiety is mirrored by the children.
PT: Tell the children that their fathers are wise and know how to watch for signs of a tsunami, and know to run to the hills if one comes. Remind and show the children to calm themselves like we just showed you.	An attempt to reassure teachers and decrease their own anxiety.
T: When is another tsunami coming?	A question revealing this teacher's anxiety and misunderstanding that Americans know all. In fact, some American scientists in Hawaii did know 30 minutes prior that the tsunami was coming, but there was not an adequate warning system in Sri Lanka.
PT: We do not know for sure, but we do know how to look for signs of water receding quickly. There are no signs now, so we know we are safe now.	An attempt to be honest, yet to empower them with information, self-trust, and sense of safety in the here and now.

In addition to addressing teachers' and parents' concerns, mental health professionals should inform them about children's typical and atypical responses to disasters, as well as methods of teaching children coping strategies. We provided teachers written material that was translated in their native language. We demonstrated play therapy techniques such as a puppet show with the help of the translator. Then we encouraged teachers and parents to implement play therapy techniques with the children and answered any questions they had. We taught teachers the following puppet show, and they performed it for Sri Lankan children in refugee camps.

Content of Session	*Rationale/Analysis*
OLD PUPPET: Hello, everyone. My name is ____________, and I am old and wise.	The play uses a "wise, old" animal such as an elephant and a "young, scared" animal such as a tiger cub to facilitate the teaching process.
YOUNG PUPPET: My name is ____________, and I am young and scared.	
OP: We are here today to learn about the tsunami.	Anticipates questions and fears children might have, and

	projects them onto the young puppet. This validates children's feelings.
YP: What is a tsunami? Is it a monster?	
OP: No. Do you, children, know what a tsunami is? (*Lets children answer; then:*) A tsunami is big waves of water that come on the land.	Assesses children's understanding; then provides factual information in a simple manner.
YP: Do you know what caused the tsunami? Was someone mad at us? Did someone put something in the ocean?	Anticipates common cognitive distortions and projects them onto the young puppet.
OP: No. Do you, children, know what causes a tsunami? (*Lets children answer; then:*) A tsunami is caused by an earthquake under the ocean. Water is on top of two pieces of land that are next to each other. One piece of land goes under the other. This forces the water away from the beach. Then the land on the bottom pushes the land on top off. This pushes the water toward the beach in a *big* wave.	Again, assesses children's understanding; then provides factual information in a simple manner.
YP: How can we help ourselves be safe?	
OP: Good question. What ways do you know, children? (*Lets children answer; then:*) OK. Now we know: (1) Run away from the water! Stop everything you are doing, and do not worry about what you are wearing. Just keep running inland or uphill away from the ocean. (2) If you see the water going out far into the ocean and animals moving away from the water, follow the animals inland. Don't look back. (3) Stay inland or uphill all day. Tsunamis can happen more than once in 24 hours, the same day. Don't go back to check the ocean until the police tell you it is safe.	Assesses children's understanding; then teaches coping strategies and addresses common barriers to coping strategies. For example, many females did not run from the water because they were not dressed properly and thus drowned.
YP: What happens after the tsunami?	
OP: Some people have to move to new places. People are busy cleaning and rebuilding. Many adults and children become sad, worried, scared, confused, or angry.	Explains expected changes. Validates common emotions.
YP: Is this bad?	

OP: No, it is normal to feel this way after something scary happens. Many children—even teenagers—will have scary dreams, wet the bed, fight more, or need more attention. Many children cry and don't know why. Many children may want to stay near adults all the time, too. Children, what other changes might children have? (*Lets children answer.*)	Normalizes common symptoms. Elicits and assesses other symptoms children may experience.
YP: I'm glad to hear these are normal things that happen to children after something scary. How long will these things last?	Addresses the concern that symptoms will last forever, and sets expectations of normal recovery while allowing for atypical responses.
OP: For many children, these changes only last a short time. For some children, they last longer. The most important thing is to tell an adult and learn to help yourself and others calm down.	Encourages talking to an adult, and increases sense of hope and power that they can do something to improve.
YP: What can we do to help one another?	Elicits and confirms positive coping strategies that are culturally and developmentally appropriate.
OP: Good question! Children, what do you do to help others calm down and feel better? (*Lets children answer; then:*) Yes, you can (1) pat someone on the back or hold hands, (2) play with each other, (3) sing, (4) dance, (5) breathe deeply and slowly, (6) pray or meditate, (7) read or look at books, (8) say to yourself that you are safe now, (9) think happy thoughts, and (10) talk to an adult.	
YP: Will things get better? Will I feel better?	
OP: Yes! We all need to work together to make life better. We will remind ourselves that we are safe now. Tell me what you will do to help yourself and a friend feel better? (*Lets children answer.*)	Fosters hope that children and the community will be better. Reviews coping strategies. Ends on a positive note!
YP: Let's all be happy and dance!!!	

One challenge with this intervention was identifying cultural taboos and revising activities accordingly. For example, originally we used dog puppets for the show. Then we learned that many Sri Lankan people do not have the same affection for dogs as do Westerners. Rather, they view them as dirty scavengers that roam the streets. Hence it was more appropriate to use a tiger or an elephant puppet. We also encouraged teachers and parents to revise other activities as necessary to make them more culturally appropriate and to address local concerns.

Mental health professionals should also teach teachers and parents basic filial therapy principles and skills (Landreth & Bratton, 2006; Guerney, 2000). Although time and conditions may not allow for the formal 10-session model of filial therapy, implementation of this model's principles and skills may create a healing atmosphere to improve children's emotions and behaviors. The basic filial principles appropriate immediately after a disaster are as follows (Landreth & Bratton, 2006, p. 78):

- Establish an atmosphere of consistency and predictability for the child.
- Understand and accept the child's world.
- Facilitate decision making by the child.
- Provide the child with an opportunity to assume responsibility and to develop a feeling of control.

Previous studies found that teachers who implemented these filial therapy skills increased communication of empathy and acceptance and promoted positive behavior change in children (Post, McAllister, Sheely, Hess, & Flowers, 2004; Smith & Landreth, 2004). Hence teachers' implementation of reflecting feelings, returning responsibility, encouraging, and setting therapeutic limits may also facilitate children's recovery after a disaster. APT team members found that Sri Lankan teachers responded favorably to these filial therapy principles. One challenge for this intervention was arranging for extended training time. Teachers and parents were already overwhelmed and exhausted, and had limited time. One group of teachers could attend training for only 1 hour while older children watched the younger children. It may be helpful to assign most of the team members to interact with the children while one or two others train the teachers.

Mental health professionals should also provide written, translated resources to parents to guide them in their children's recovery. For example, La Greca, Sevin, and Sevin's (2005) workbook, *After the Storm: A Guide to Help Children Cope with the Psychological Effects of a Hurricane*, provides basic psychoeducational activities such as a "stress gauge" for parents to assess on a scale of 1 to 10 how stressed their children are, and a worksheet to plan how to stay healthy. These activities should be assessed for cultural relevance and translated as needed. To make these psychoeducational activities more developmentally appropriate, mental health professionals should teach parents some basic play therapy techniques, such as puppet play and art activities.

Children's Interventions

Children's interventions in international disaster response are most efficiently provided in small- or large-group formats, since translators will be needed. In preparation for the APT tsunami disaster response in Sri Lanka, Shelby, Bond, Hall, and Hsu (2004) integrated play therapy techniques into the National Center for PTSD (2005) *Psychological First Aid* protocol for preschool and elementary school children. This protocol focuses on seven objectives, as described below.

Normalize Symptoms. Mental health professionals should normalize children's responses to disasters, such as bedwetting or aggressiveness, by informing children of typical reactions. This information can be conveyed through puppet shows (as described above), art activities, or symptom charades (i.e., one person acts out a symptom, and others guess what symptom it is). Caution should be used in selecting storybooks to normalize symptoms, as some words or concepts do not translate well. For example, in Sri Lanka, a story about a "wise tree" that helped children was mistranslated as a "white angel." Although this was not intended, it was culturally offensive, so clarification and apologies were made.

Manage Hyperarousal. Mental health professionals should teach children self-soothing, relaxing techniques to calm their bodies and deactivate their "fight-or-flight" response after a disaster (Perry et al., 1995). These procedures include (1) taking deep breathes through playful activities such as blowing soap bubbles or balloons; (2) progressive muscle relaxation by tensing and relaxing muscle groups; and (3) focusing on positive images by drawing happy places, engaging in mutual storytelling with a positive ending, or meditating on peaceful places (Felix, Bond, & Shelby, 2006; Shelby et al., 2004; Webb, 2004). For example, since many Sri Lankan children were afraid to go to the beach after the tsunami, some APT team members taught children deep breathing and positive images through the following song, which was set to the tune of "Twinkle, Twinkle, Little Star": "I am safe and I am strong. Take a breath and sing this song. I'm growing stronger every day. I know that I'll be OK. I am safe and I am strong. Take a breath and sing along." APT members taught meditation through the culturally familiar practice of yoga. Sri Lankan children were adept at yoga, and adults enjoyed seeing their cultural practice honored.

Manage Intrusive Reexperiencing. Mental health professionals should teach children methods of managing intrusive thoughts of disaster-related events that are encoded in their implicit memory (Perry et al., 1995). These procedures include (1) "changing the tape" by replacing negative thoughts with a predetermined positive song, story, or saying, such as "I'm safe right now and I know it because I have . . . "; and (2) grounding activities such as rubbing stomach and hands together (Felix et al., 2006; Shelby et al., 2004). Play therapists can also amend Baranowsky, Gentry, and Schultz's (2005) "5-4-3-2-1" sensory grounding and containment procedure by asking children to play a "3-2-1" game. For this game, children are asked to identify three objects everyone can see, three sounds everyone can hear, and three things everyone can touch; then two things they can see, hear, and touch; followed by one thing they can see, hear, and touch. This activity helped Sri Lankan children refocus on the here and now and realize that their surroundings were safe.

Increase Accurate Cognitions. Due to their egocentric and concrete cognitions, some children may misattribute the cause of disaster to their bad dreams or to their own or someone else's bad behavior. Mental health professionals should identify their misattributions and give accurate information. Possible procedures include (1) making a Q-sort of possible reasons for the disaster and asking children to sort them as true or untrue; (2) creating a "blame box" for younger children to put in drawings of who or what they blame, and then drawing the correct reason together; (3) developing a puppet show in which one puppet asks about misattributions and another puppet gives accurate reasons; and (4) acting out a radio show of people calling in with questions and an expert giving correct information (Felix et al., 2006; Shelby et al., 2004). When the young puppet in the puppet show described above timidly asked if the tsunami was caused by an angry person or by someone putting something in the ocean, Sri Lankan children loudly responded in unison with the Tamil equivalent of "No." Their powerful, united response seemed to alter their collective cognition to an accurate one, which the confident older puppet confirmed.

Increase Effective Coping. Mental health professionals should help children differentiate between effective and ineffective coping strategies, and should help them develop numerous, culturally appropriate adaptive coping strategies. These procedures may include (1) writing or drawing maladaptive coping strategies on cards and telling children to "pass the trash"; (2) playing card games in which children find pairs of adaptive coping strategies and throw out maladaptive strategies; (3) playing coping charades in which children act out positive coping strategies; and (4) organizing developmentally appropriate, cooperative play or games such as Duck, Duck, Goose and relay races (Felix et al., 2006; Shelby et al., 2004). For example, in Sri Lanka, APT members guided children in making a "coping bracelet" of five colorful cards on which they drew effective coping strategies.

Seek Social Support. Mental health professionals should teach children appropriate ways of seeking healthy social support and decreasing unhealthy social withdrawal. These procedures (Shelby et al., 2004) include (1) role-playing how to ask for social support from four different sources, such as peers, parents, staff, and teachers; (2) making "support coupons" by writing or drawing requests for help on paper and giving one of these to a trusted peer or adult when help is needed; and (3) creating a paper doll support chain in which linked images of dolls are labeled with names of people who provide support. While making paper doll support chains at one Sri Lankan refugee camp, a group of girls noticed a girl sitting by herself and asked her to join them in making their chain. She responded with a smile and included her new friends in her own paper doll support chain.

Foster Hope. After a disruptive disaster, mental health professionals can be a part of the compassionate humanitarian response that reignites children's hope and positive images for the future (Shelby et al., 2004). Procedures from Shelby et al. (2004) to increase hope include (1) role-playing family and community rebuilding efforts; (2) creating stories, poems, or songs that express hope; and (3) identifying community support projects in which children can participate, such as making thank-you cards for police officers or building a rock garden. For example, in Sri Lanka, APT members guided children in finding natural objects on the beach and placing them in a sandbox to symbolize the rebuilding of their community. These interventions foster hope not only in children, but also in adults who witness the therapists working with their children.

One of the most powerful ways to foster hope was demonstrating care just by being there. Families and children were touched by the fact that we cared enough to come thousands of miles to offer help. Consider the poem written by a Sri Lankan teacher who witnessed the interventions and positive changes in children (see Figure 16.2).

One challenge with the children's interventions described above was having enough translators for small-group activities. Our APT team recruited our driver as an additional translator. We asked the translators to rotate between groups to explain the activities. Children seemed to be happy to play gross motor games such as Duck, Duck, Goose when a translator was not available. Another challenge was the children's passive learning style. Sri Lankan children had an expectation that they were to sit and be quiet while an adult gave a lecture. It took some time for APT team members to engage the children in active learning and playing.

Team Processing and Support

A common mantra among emergency response personnel is that responder safety is paramount. Likewise, the first priority in international crisis intervention is the mental health professionals' physical and emotional safety. Team processing of daily events and mutual support may help promote therapists' emotional safety and prevent compassion fatigue (Gentry, 2002; Rank & Gentry, 2003). Specifically, we found four strategies to be helpful for our APT team providing crisis response in the eastern area of Sri Lanka. First, we participated in an after-action review at the site immediately after providing an intervention. The team members stood in a closed circle and identified together three things that went well and three things that needed improvement. This strategy allowed for immediate defusing of any frustrations, prevented blaming of others, and focused the group's attention on solutions to improve interventions.

Second, we participated in a team processing of daily events during the evening. Team members were encouraged, though not required, to state (1) what event, image, or person was most salient for them that day; (2) prominent thoughts or feelings they experienced; (3) the coping strategies they planned to utilize; and (4) their strengths and areas for growth. Emotional support and affirmation for each team member were also encouraged.

The third strategy was the therapists' participation in one-on-one supervision with a registered play therapist on the team. This strategy allowed for pro-

To my dearest kind hearts . . .
December 26, 2005

It's just a year.
It was a shock. . . .
Of course it was.
My dearest mother,
Kind father,
Friend next door,
And . . .
Even my hopes & thoughts . . .
All vanished in no time.
Having lost everything,
I saw you
As my mother, father . . .
And you meant a lot to me.
It is because of your kindness,
There's still a drop of hope
In the minds of children like me.
They were not just the things
Which you brought to our camps.
You brought happiness to us,
You brought kindness to us.
And above all,
You brought life to us.
There is humanity,
Still . . . There is humanity.
It didn't die.
It rose from your hearts.
I saw God in you,
When I was bare handed.
Thank You for your hard works,
Commitments, efforts
And Motherly care.
May God bless you and your family.

With lots of gratitude from,
N. Prashanthan
Teacher
Pandiruppu-02, Kalmunai, Sri Lanka
(On behalf of the affected people)

FIGURE 16.2. A poem written for members of the APT team by a Sri Lankan teacher, N. Prashanthan. Reprinted by permission.

cessing of any personal issues and teaching of needed skills. The fourth strategy was participating in local tourist and recreational events. For the example, the team visited a well-known Hindu temple one evening and rode an elephant together the next day. These events promoted understanding of local culture and increased a communal sense of light-heartedness, thereby decreasing the emotional intensity of providing trauma interventions.

Follow-Up

One of the most valuable contributions mental health professionals can make to international crisis intervention is to mobilize resources upon returning home. APT team members were inundated with media attention and requests for presentations to various groups, such as schools, religious groups, and professional organizations. These concerned and curious people trusted us to tell how they could help. It was crucial to capitalize on these opportunities in order to mobilize resources for the people and communities still in need. For example, I shared pictures of Sri Lankan children, described their specific needs, and provided relief organizations' website and phone numbers so people could make donations. As a result, a major telecommunications company made a substantial donation. Another APT member, Patricia Clark, mobilized community members to raise $20,000 to rebuild a preschool that was destroyed by the tsunami. She also arranged for Sri Lankan preschool teachers to travel to the United States for specialized training in teaching methods and trauma interventions.

Partnering with international institutions such as universities and government agencies for infrastructure development is also needed. Mental health professionals should share their valuable knowledge and experience gained in their international work with indigenous professionals who are organizing sustainable services. For example, I gave a presentation entitled *Psycho-Social Education for Elementary School Children Affected by the Tsunami* (Baggerly, 2005) to international professionals at the Asia–Pacific Academic Consortium for Public Health. Subsequently, I was able to consult and collaborate with Sri Lankan professors in developing training on children's disaster recovery interventions for Sri Lankan professionals. Mental health professionals involved in international crisis response are responsible for following up with resource development and professional collaboration. In doing so, they continue to "be there" to help children heal and recover from the devastating impact of natural disasters.

CONCLUSION

As the number of children affected by natural disasters continues to increase worldwide, mental health professionals need to be prepared as global citizens in a global village. Natural disasters can have a major negative impact on children's behavior, cognitive functioning, mental health, and physical development, as well as on community resources. Most children will experience typical, short-term symptoms such as nightmares and avoidance of trauma triggers, while some children experience full-blown clinical symptoms of PTSD.

Guidelines for international crisis work can be categorized into preparation and interventions. For preparation, mental health professionals must understand the following disaster relief principles: (1) Follow the incident command structure; (2) discern phases of a disaster; (3) expect children's normal recovery; (4) implement the "six C's" of disaster mental health; (5) maintain hardiness and flexibility; (6) utilize developmentally appropriate approaches of play; and (7) gain information about the specific natural disaster and country. For interventions, mental health professionals should do the following: (1) Train translators; (2) consult with teachers and parents about normal symptoms, coping skills, and filial therapy principles; (3) provide small- and large-group children's interventions of normalizing symptoms, managing hyperarousal, managing intrusive reexperiencing, increasing accurate cognitions, increasing effective coping, seeking social support, and fostering hope; (4) facilitate team processing and support; and (5) follow up with resource development and professional collaboration.

Mental health professionals trained in play therapy are uniquely poised with developmentally appropriate knowledge and skills to facilitate children's healing after an international disaster. Play and caring are understood in any language. Mental health professionals are encouraged to follow these guidelines for preparation and intervention, so that they can be global citizens in a global village that helps children recover after international disasters.

Study Questions

1. After a natural disaster, what are the differences between the needs and resources of children in developing countries (e.g., Sri Lanka, Indonesia, etc.) versus children in developed North American countries (e.g., the United States or Canada)?
2. Some cultures have different views on children's responses or symptoms after a crisis. How might a Western view of children's responses and diagnoses such as PTSD differ from an Eastern view?
3. How will you know whether you, as a mental health professional, should respond to an international crisis? What criteria should you meet before you deploy?
4. Think of a cultural group or country to which you would be likely to respond in the event of an international crisis. What cultural adaptations would you need to make when you provide play therapy interventions?
5. When responding to an international crisis, what would you do to prevent cultural misunderstandings? How would you respond if you unwittingly committed a cultural taboo or offended your cultural hosts?

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Chapter 17

The Crisis of Family Separation Following Traumatic Mass Destruction

JUNGIAN ANALYTICAL PLAY THERAPY IN THE AFTERMATH OF HURRICANE KATRINA

Eric J. Green

> It is through the dark night of the soul that we discover our depth.
> —THOMAS MOORE (2004, p. 87)

On August 28, 2005, New Orleans Mayor Ray Nagin referred to "the storm that most of us have long feared" ("Katrina Heads for New Orleans," 2005). A path of catastrophic devastation was carved along portions of the U.S. Gulf Coast when Hurricane Katrina made landfall slightly east of New Orleans on August 29, 2005. After slamming into Florida just days before, Katrina had strengthened into a Category 5 storm with maximum sustained winds of over 175 mph and waves as high as 30 feet as it made its way across the warm waters of the Gulf of Mexico. By the time it made landfall in Buras, Louisiana, Katrina had weakened slightly to a Category 4 storm, still packing deadly winds and thrusting an immense 15-foot storm surge across the low-lying regions of southern Louisiana, Mississippi, and Alabama. Katrina was further downgraded to a Category 3 storm, although it was still generating 120-mph winds and dropping as much as 8–15 inches of rain, as its eye moved east of New Orleans—a city mostly lying below sea level (Horn, 2006).

Causing massive breaches in levees that separated Lake Pontchartrain and Lake Borgne from New Orleans ("Hurricane Katrina," 2006), Katrina flooded 80% of the city and completely disrupted the necessary staples and conveniences of modern life: electricity, clean running water, sewage facilities, food supplies, telephone communications, and transportation (Horn, 2006). Additionally, Katrina (1) caused over 1,836 deaths; (2) resulted in over $75 billion in damage; (3) displaced hundreds of thousands of people (Nasser & Overburg, 2006); (4) ruined entire towns (e.g., Gulfport, Mississippi) and huge amounts of urban infrastructure over the expanse of the Gulf Coast area; (5) destroyed over 200,000 homes in Louisiana alone; and (6) left 50,000–100,000 people stranded in flooded areas, including some on rooftops for several days with no food or drinking water while awaiting airlift evacuations from emergency officials (U.S. Congress, 2006).

In Louisiana, over 26,000 people found shelter at the Superdome in New Orleans, which the municipal government designated a "refuge of last resort" for citizens. Due to the oppressive heat, lack of electricity and operating cooling systems, and general pandemonium caused by the rising flood waters, the Superdome became a grisly site for many evacuees as human feces and urine overflowed from hundreds of broken toilets, and social order became precariously destabilized. Moreover, four people were confirmed dead while sheltered in the Superdome, and another six died while awaiting evacuation from the New Orleans Convention Center (Stevens, 2006). On September 3, 2005, Homeland Security Secretary Michael Chertoff described the aftermath of Hurricane Katrina as "probably the worst catastrophe, or set of catastrophes" in the country's history, referring to the devastating effects of the hurricane and the deadly deluge of New Orleans ("The Aftermath of Katrina," 2005).

Some reports estimated that 372,000 children, many of whom were African Americans living at or below the poverty level, were displaced by Katrina (Eriksen & Ellison, 2006). Disaster sociologists noted that many families were separated or endured extreme hardship, due to the mass exodus of people from the Gulf Coast during the chaos of Katrina. The exodus was accompanied by tragic and sudden deaths from flooding; harrowing reports of lost children separated from their caregivers amidst mass confusion; and displaced family members relocated to other parts of the United States, with no means of finding or communicating with the loved ones left behind in the devastated Gulf region (Albano, 2005; David, 2005; Koch, 2005; Memmott, 2005).

The aim of this chapter is to assist mental health professionals in facilitating psychological healing for children and families separated and/or traumatized by a natural disaster. Specifically, it describes (1) the psychology of traumatization through family separation in catastrophes; (2) Jungian perspectives on a child's inner world during a life-threatening crisis; (3) evidence-based practices and the utilization of a Jungian play therapy technique to facilitate healing; and (4) a clinical vignette involving Jungian analytical play therapy with a young trauma survivor and his family after Katrina. The information provided comes from theoretical and evidence-based research, and from my participation with the Johns Hopkins University Play Therapy/Mental Health Initiative team that was deployed in September 2005 to southern Louisiana following Hurricane Katrina.

THE PSYCHOLOGY OF FAMILIAL TRAUMA DURING A LIFE-THREATENING CRISIS

The etymology of the word "crisis" provides insight into its historical meaning. Echterling, Presbury, and McKee (2005) described the Chinese character for "crisis" as a combination of two symbols; one represents "danger," and the other represents "opportunity." Moreover, the Greek word *krisis* literally means "a turning point." Therefore, the word "crisis" can be deconstructed to mean both "danger" and "hope." Families that endure a situational crisis such as a natural disaster may face a variety of assaults to the family structure, including intense interpersonal conflict, hysteria, loss of valuable or irreplaceable personal items, grief, sudden separation, and death. During a natural disaster, typical patterns of posttraumatic responses in families can be codified into the following three distinct phases (Collins & Collins, 2005):

- Emergency (or acute)
- Inhibition or avoidance
- Adaptation

In the emergency phase, comprising the days and weeks immediately following a disaster, individuals tend to be hyperaroused both physically and emotionally. Typical responses in the emergency phase include (1) *emotional effects* such as fear, despair, helplessness, and grief; (2) *cognitive effects* such as intrusive thoughts, flashbacks, extreme anxiety, and confusion; (3) *physical effects* such as fatigue, insomnia or hyposomnia, and loss of appetite; and (4) *social effects* such as alienation, withdrawal, and interpersonal discord. During the inhibition phase, family members are no longer receptive to discussing or thinking about the crisis they experienced together; however, relational conflicts, psychosomatic complaints, and nightmares generated by the crisis intensify. The adaptation phase occurs several months to years after a crisis, when psychological and social impairments begin to diminish.

Some survivors of a natural disaster that is life-threatening and unexpected/uncontrollable develop symptoms or diagnoses of acute stress disorder (ASD) soon after the disaster. In extreme examples of families coping with disasters, both children and adults develop symptoms or full diagnoses of posttraumatic stress disorder (PTSD). (For full descriptions of the diagnostic criteria for ASD and PTSD, as well as other mental disorders that may be sequelae of trauma, see American Psychiatric Association, 2000, and Nader, Chapter 2, this volume.) Steinglass and Gerrity (1990) found, however, that survivors of disasters who felt as though they were part of a family or community when the disaster occurred were less likely to experience PTSD than survivors of a disaster with no familial or community involvement. This reflects the positive impact of support factors in Webb's tripartite assessment (see Webb, Chapter 1, this volume).

Contributing to the family's psychological detriment during a disaster, the loss of resources—including homes, cars, employment, health, money, and personal or sentimental belongings—can adversely affect interpersonal/familial functioning. When such losses are combined with direct injury to self or family members, displacement, separation from family, and the experience of hysteria or mass panic during a crisis, a family's psychological constitution may show signs of serious fragmentation. Specifically, when the family's support system becomes overwhelmed or unavailable, vulnerability and impeded mental functioning may surface, thereby rendering children defenseless in the wake of simultaneous attacks on their tenuous residual resources as their primary caregivers are helpless in coping with their own psychological vulnerability (Hoven et al., 2004). In other words, not only do a disaster and the possibility or actuality of subsequent interpersonal separation affect the familial system as a whole, but children are especially vulnerable and can display reactive behaviors along with pronounced psychological deterioration when the caregivers or previously stabilizing adult figures in their lives are rendered inadequate or incompetent (Benz & Axelrod, 2004; Busuttil & Busuttil, 2001; Collins & Collins, 2005).

A JUNGIAN PERSPECTIVE ON THE CHILD'S INNER WORLD OF TRAUMA

In this section, I offer theoretical commentary on the phenomenology of daimonic figures that appeared in many children's artwork and dreams following Katrina. Kalsched (1996) describes the word "daimonic" as derived from the Greek *daimon*, which refers to "division"— breakthroughs or a divide between the conscious and the unconscious realms. Where significant trauma, such as separation or the intense disruption of the family system due to mass destruction, has rendered psychic integration inoperable, children may dissociate (Jung, 1959). Dissociation is represented by the daimon that personifies the psyche's dissociative defenses (Kalsched, 1996). In dissociation, the child's psyche tricks itself into cutting off the harmful, unbearable external elements of the trauma and suppresses it to the unconscious, so the trauma becomes removed (or suppressed) from consciousness. For children who have experienced catastrophic devastation to their fragile egos (the "ego" is the center of consciousness, the "I" as people know themselves)—as happened to those who were rescued from life-threatening floods and saw dead bodies floating in putrid, stagnant water during Katrina—the psychological sequelae of the trauma become toxic to their interior lives. Specifically, Jung (1963) stated that these trauma-induced "complexes" (strong images surrounded by gripping emotions) are represented in children's dreams and artwork by diabolical images, such as monsters, villains, or other dark figures. For example, Anthony, a 9-year-old boy who barely survived Katrina's flood waters only to be tragically separated from his mother amidst a crowd, drew a series of pictures that contained variations of the same elements: water, a sinking ship, and a black shark fin placed ominously within the water (see the case example presented later in this chapter). (All identifying information about clients presented in this chapter has been disguised.)

When an intolerable level of anxiety overwhelms a child's vulnerable ego—as in the case of Anthony, who was trapped in a smolderingly hot attic with no food or water for 2 days—psychic disintegration occurs that threatens to destroy the child's personality (Jung, 1964). To prevent this annihilation, Kalsched (1996) theorized that an archetypal self-care system comes to the child's rescue—an archaic mechanism that creates a defensive splitting to encapsulate the child's fragile personal spirit in safety by banishing it to the unconscious. The child's psychic defense against intolerable pain sends an archetypal daimon, or an image from the self-care system, to help the child dissociate from the immense anxiety.

Moreover, when unimaginable anxiety overwhelms the child during or immediately following a natural disaster, the child's "transitional space" is severely compromised. According to Kalsched (1996), the "transitional space" is the realm between the inner and outer worlds where the child learns how to play creatively and utilizes symbols. Severe traumatic anxiety effectively dismantles this space and extinguishes the child's capacity to be creative through symbolic play, thereby inducing a fantasy state that is soothing and serves as a pathogenic anxiety-avoidance mechanism. This escape of fantasy and avoidance can become a pathological obsession for the child's conscious state, an autohypnotic twilight existence where a delusive reality becomes the *only* reality. For example, Anthony repeatedly had dreams of an angel taking care of a baby, and he stated that the baby represented himself. In this instance, the "good mother" archetype appeared in Anthony's dream to nurture the wounded child and relieve some of the psychic disintegration. However, after he and his family took refuge at a Red Cross shelter, Anthony became fixated with playing video games that contained aggressive themes, and he neglected to eat and even defecated in his pants a couple of times because of his inability to recognize his somatic needs. Possibly the video games depicted violent scenes that resonated with his own traumatic experiences.

Jung (1959) believed that symbolic communication, which may be temporarily severed during extreme trauma, guides a child toward healing and fulfillment by connecting the unconscious psyche to the ego (Allan & Bertoi, 1992). Children who are separated from family members or lose one or more members to death during a disaster suffer a *disconnection* from the ego's stability in managing the external world. Specifically, children affected by disasters often display an extremely poor connection with their unconscious because of the erosion of the transitional space between their outer and inner worlds, due to the destabilization of their "good enough" parental introjects (images and the feelings associated with those images of the "good mother" or "good father" archetypes that provide safety).

In order for the child's ego to resolve the devastating effects of trauma, a meaningful integration must occur. Meaning, according to Kalsched (1996), occurs when children's bodily excitations are given mental representation by transitional archetypal figures, so that they eventually can reach verbal or symbolic expression and be shared with a trusting, caring individual. Helping the child recover the tenuous transitional space, so that his or her creative capacities are restored, entails the enhancement of the connection between the unconscious and conscious (Allan & Brown, 1993; Jung, 1963). This results in strengthening the child's ego and its capacity to explore polarities that are both painful and comforting (e.g., anger–forgiveness, pride–humility, pathological aggressiveness–healthy assertiveness). From a Jungian perspective, this *coniunctio oppositorum*, or joining of opposites—portrayed in the child's drawing, painting, and/or verbalization of symbolic images (Furth, 1988) from dreams or the unconscious, in the presence of a nonjudgmental, empathic therapist—facilitates psychological healing after extraordinary adversity (Allan, 1988; Green, 2005).

EVIDENCE-BASED PRACTICES

The empirical evidence base for various methods of counseling young trauma survivors is incomplete in the current literature, due to a paucity of conclusive studies demonstrating the best treatment possible. However, Shelby (2000) and Shelby and Felix (2005) describe an intervention that offers a variety of evidence-informed strategies for mental health practitioners to provide effective posttraumatic treatment for children: posttraumatic play therapy (PPT). PPT involves integrating directive, trauma-focused play therapy with nondirective play therapy. Its developers recommend that clinicians assess symptoms, evaluate children's coping resources, and utilize diagnosis to select the most appropriate technique in five central areas (see Table 17.1). Additionally, the PPT model advocates for guardian/parental involvement in trauma treatment as an effective adjunct to any type of intervention. For a complete list of techniques for distinct patterns, see Shelby and Felix (2005).

Directive treatment approaches, particularly cognitive-behavioral therapy (Knell, 2003), are generally preferred for counseling children affected by trauma, except in instances when children dissociate (Bryant & Harvey, 2000). Cognitive-behavioral play therapy's premise is that because cognitions shape behaviors, the reconceptualization of distorted or faulty thinking or attributions of traumatic events by children will change their maladaptive behaviors and relieve anxieties. According to Webb (2006), young children's egocentric thinking may cause them to believe that they are solely responsible for problematic or disastrous occurrences. By utilizing therapeutic toys such as puppets or relaxation exercises, the cognitive-behavioral play therapist models more accurate response

TABLE 17.1. Appropriate PPT Techniques for Various Groups of Symptoms

Symptoms	Techniques
• Intrusive reexperiencing	• Directive trauma-focused approaches
• Arousal	• Directive relaxation
• Dissociation/extreme avoidance	• Directive or nondirective focus on skills
• Loss of social competence	• Directive or nondirective approaches
• Traumatic grief	• Directive or nondirective focus on grief

to harmful situations—thereby educating the child, possibly changing his or her understanding of the traumatic event, and perhaps instilling more adaptive behaviors (Webb, 2006; Russ, 2004).

Nondirective play therapy has its own advantages in counseling traumatized children. Its premise is that the child is allowed to lead the session, and it focuses on the therapeutic relationship, rather than on therapist-led interventions that might induce further anxiety (Landreth, 2002; Landreth & Sweeney, 1997). Anecdotal evidence indicates that children ultimately enjoy mastering the direction of the play and may subsequently regain a mastery of their own emotions and behaviors (Sweeney & Landreth, 2003). Ray, Bratton, Rhine, and Jones (2001) conducted a meta-analysis of 94 directive and nondirective research studies assessing play therapy's efficacy and found that clients exhibited more adaptive behaviors and fewer maladaptive behaviors after play therapy interventions as compared to their behaviors before entering the play therapy process.

Several studies in the literature support utilizing experiential art activities with young children to achieve a developmentally appropriate sense of control over an adverse situation (Furth, 1988; Gil, 1991; Green & Christensen, 2006; Halprin, 2002; Russ, 2004). For instance, Shelby and Felix (2005) describe the "experiential mastery technique" (EMT), where children are asked to (1) draw pictures of their strongest fears (e.g., being separated from their mothers during a flood); (2) depict their emotions about the drawings (e.g., "Mommy, where are you and why aren't you with me, because I'm very scared and don't know how to swim?"), and (3) do what they wish to the drawings to gain control over their fears (e.g., drawing their mothers holding them). Shelby and Felix (2005) investigated the effectiveness of EMT by applying it to young children directly affected by Hurricane Andrew, and they later reported significantly less fear of the storm.

SERIAL DRAWING: A JUNGIAN ANALYTICAL PLAY THERAPY TECHNIQUE

"Serial drawing" is a therapeutic approach based on Jungian concepts that involves having a child produce artwork over time, thereby providing a view of the child's inner world to the therapist (Green & Ironside, 2004). After a therapeutic relationship and trust are formed between the therapist and child, problems are expressed symbolically in the artwork, and healing and resolution of inner conflicts occur (Allan, 1988; Furth, 1988; Green, 2004). The serial drawing technique involves a therapist's meeting with a child regularly and asking him or her to "draw a picture while we talk." Jung (1963) believed that in times of significant crisis, children can turn inward toward the unconscious for dreams and images that carry within them the potential for healing—otherwise known as the "self-healing archetype." Within this perspective, the Jungian play therapist does not analyze the child's images, but rather (1) encourages the child to make the images freely, with little to no direction from the therapist; (2) allows the child to absorb the images fully, so that the images can lead the child wherever he or she may need to go (toward self-healing); and (3) links the meaning of the symbols with the child's outer world, so that the child's ego can accept and integrate the bridge between "transitional spaces." To reiterate, the process of serial drawing alone does not heal; rather, the self-healing archetypes in children are activated by a curative alliance with a nonjudgmental therapist (Green, 2006). The serial drawing provides for a safe expression and exploration of feelings associated with the child's traumatic experience.

According to Walsh and Allan (1994), a therapist may employ three different therapeutic styles when utilizing the serial drawing technique with a child: (1) directive (the therapist gives the child specific images to draw related to the trauma); (2) nondirective (the therapist simply says, "Draw whatever you'd like"); and (3) semidirective (the therapist intermittently requests the child to redraw a specific symbol already produced, to explore its inherently healing capacities further). While individual children move at their own pace in self-healing according to their developmental stage and also the nature of the trauma, general patterns in producing images in the serial drawing technique have been observed by Allan (1988). In the *initial stage* (typically the first few sessions), the drawings (1) provide a glimpse of the child's interior illustrated by symbols that reflect the source of trauma; (2) reflect loss of internal or external control with feelings of despair; and (3) establish initial rapport between the therapist and child. In the *middle stage* (generally sessions 5–8), the child's drawings reflect (1) a pure expression of intense emotion; (2) struggles between conflicting internal polarities (loss of control vs. mastery); and (3) the deepening of the therapeutic relationship between the child and therapist, which is exemplified by the child's talking directly about a traumatic issue or disclosing private and painful memories of the crisis to the therapist. In the *final stage* (sessions 9–12 and beyond), the child's drawings tend to depict (1) images that reflect a sense of mastery, self-control, and valuation; (2) scenes with positive imagery; (3) depictions of the Self (intact self-portraits or mandalas [circular shapes connoting wholeness/integration]); (4) scenes that are humorous with no macabre references; and (5) artwork representing autonomy from the therapeutic relationship.

All children do not pass through all of the aforementioned stages or follow them sequentially, and therapists should expect the unexpected when conducting serial drawing. In addition to a tolerance for ambiguity, therapists should provide an atmosphere that contains unconditional positive regard, trust, genuineness, warmth, and empathy, which may assist children to draw freely in a protected space (Hebert & Green, 2005). To process the serial drawing and amplify its symbols, Allan (1988) has suggested that the therapist ask the child one or more of the following questions: (1) "Does this picture tell a story?" (2) "I'm wondering if you can tell me what is happening in this scene?" (3) "If you could give this picture a title, what would it be?" (4) "If you were inside this picture, what would it feel like?" (5) "What went on in the story before this scene occurred? What happens next?" (6) "Could you tell me what you were thinking or feeling as you drew this?" and (7) "What does this [identifying a certain object or symbol in the picture] mean to you?"

During the processing of artwork, it is important for the therapist to remember that both verbal and nonverbal communications to the child should reflect support, as the child will come to realize that both good and horrible feelings are acceptable to convey in the therapeutic relationship. The next section demonstrates many of the Jungian principles outlined thus far in the chapter: It describes a clinical vignette involving Jungian analytical play therapy with a 9-year-old trauma survivor separated from his primary caretaker during Hurricane Katrina, then later reunited with his family at a Red Cross shelter.

THE CASE: ANTHONY, AGE 9

Family Information

Father: Gerry, mid-30s, unemployed
Mother: Belinda, early 30s, secretary at an oil company
Son: Anthony, 9, fourth grade

Presenting Problem

Almost immediately upon arrival at the Red Cross shelter in Lafayette, Louisiana, approximately 2½ weeks after Katrina made landfall east of New Orleans, I was approached by Gerry. A modest man with a low-pitched voice and a disheveled appearance, Gerry asked my assistance with helping his son, Anthony, and provided me with the following background information. Gerry, Belinda, and Anthony lived in an impoverished, dilapidated, crime-ridden section of New Orleans—the Ninth Ward. They did not have transportation and were unable to vacate the city when Mayor Nagin issued the mandatory evacuation order the night before Katrina came ashore. As Katrina's eye passed over New Orleans, their situation became precipitously dangerous. Specifically, the rising flood waters seeped into their living room through the home's front door. Riding out the storm overnight, they believed that the worst was behind them. As the rain and wind continued to pummel the city into the next day, however, the levees were breached, and the true horror began. Gerry described the rising waters as pouring into his home so fast that his family barely had time to climb into their attic. The flood waters rose to the floor of the attic, completely inundating the house with water and debris. Without an escape route, the family remained stuck in the attic with no food or water for nearly 30 hours, hoping the flood waters would recede. Eventually, Gerry used his rifle (which was stored in the attic) to blow several holes through the roof so he and his family could escape. The oppressive heat, combined with the humidity, reached sweltering heights as the family sat on the roof nearly 8 hours in desperation. Finally, the family was spotted and airlifted to the New Orleans Convention Center. While there, Belinda was inadvertently separated from Gerry and her son, due to the mass hysteria of the crowd—which comprised thousands of angry, shocked, and terrified people. Luckily, Gerry and Anthony remained together and were bussed to a Red Cross shelter in Lafayette. Belinda was reunited with her family in Lafayette 3 days later.

After being separated from his mother, Anthony exhibited uncontrollable fits of crying and panic. Upon being reunited with his mother at the shelter, however, Anthony appeared mildly relieved, and he isolated himself. He spent several hours daily playing video games in the shelter. At night, Belinda said he would wake up screaming periodically, waking others up, and would then return to sleep—not remembering anything the next morning. Gerry asked if I would speak to his son, stating, "Anthony is like a different kid. It's like he's somebody else. He's very sad, and we don't know how to help him." I asked Gerry about Anthony's favorite activities, and he said that they were drawing and playing soccer.

First Contact with the Child

My initial contact with Anthony occurred in the main room of the shelter, following lunch. He was playing chess with his mother on her cot. Gerry introduced me to his son, and our first session follows:

Content of Session	*Rationale/Analysis*
Gerry: (*Looking nervously at his wife*) Belinda, I'd like you to meet Dr. Green. (*Belinda smiles and immediately looks at her son.*) Anthony, sit up, son, and introduce yourself to him.	
Anthony: (*With a bewildered look on his face*) I'm not sick. I don't need a doctor. (*Looks right at the therapist.*)	Anthony initially believes that I am a medical doctor who has come to take care of the sick people in the shelter.
Therapist: Hi, Anthony. I'm sorry to interrupt your chess game. It looks like you were winning. You must be pretty good at chess, huh? (*Anthony smiles.*) I'm not the kind of doctor that helps kids when they are sick. I'm the kind that helps kids when they have worries and maybe want to play and get their mind off of whatever is bothering them. I have an entire play area filled with toys and puppets. Why don't you come over and look at it, and see if you can find something you like? If you want, your mom and dad can come too.	I begin by trying to be polite and excusing myself for interrupting his board game. Next, I gently clarify my purpose for being there, so that Anthony does not feel embarrassed in any way in front of his parents for mistaking my profession. I give him the choice to bring his parents with him, because I want him to feel protected and safe, as I am a new face.

A: Um. No thanks.	Anthony is not all that interested in leaving his mom to go off with me to see a play area. I do not view this as resistance, but as progress toward developing rapport.
T: OK. Well, just know that I'll be over there if you ever want look at the toys, and I even have a bunch of art supplies if you like to draw or paint.	Feeling that we have made progress just by talking, I leave with an open invitation to draw—an activity Anthony enjoys—and he accepts.
A: You do? (*He looks at his mom for tacit permission. His mother nods her head agreeably and smiles.*) OK.	

After exploring the play area over a period of approximately 10 minutes, Anthony thanked me for inviting him and walked back to his parents. As he was leaving, I stated that if he wanted to come back later he could, as I would be there in the mornings and evenings. Anthony did come back the next morning, and he participated in eight play therapy sessions with me over the course of 8 consecutive days. After the eighth day, he and his family were relocated to another shelter.

Preliminary Assessment and Treatment Plan

From my initial contact with and observations of Anthony, and also from my communications with his parents, it appeared that Anthony was responding to the overwhelming stimuli of his traumatic experience by socially withdrawing, perhaps providing his psyche time to heal from the state of overstimulation. In the course of 2 weeks, Anthony had been trapped in rising flood waters; had gone without food or water for almost 2 days in squalid, blisteringly hot conditions; had witnessed his home flooded and destroyed; had been separated from his mother during a chaotic scene at an overpopulated evacuee center; and was now living in a large open room inside a shelter with people he did not know. All of these external events would appear to overwhelm the fragile ego of a child (or even adult), but Anthony seemed remarkably resilient. Nevertheless, though Anthony appeared to be in good health, his compulsive video game playing for hours at a time without speaking to anyone, his social isolation and dysphoric demeanor, and his soiling on himself were possible signs that he was suffering from traumatic stress-related symptoms. Because of the transient nature of the shelter, and the limited scope of crisis intervention counseling, I set up a basic, simple treatment plan for Anthony:

1. Provide Anthony a safe, grounded space where he could relax and feel open to share his feelings, either verbally or symbolically.

2. Strengthen Anthony's ego so that he could bolster his coping skills.
3. Reduce Anthony's anxiety (e.g., his nightmares and midnight screams, which were waking up those around him in the shelter) by allowing his unconscious to be represented in the play area, where he could begin to regain mastery of his feelings.

Anthony did indeed enjoy drawing and painting; therefore, my aim was to sit quietly and allow him to create whatever he wanted. By the time I met Anthony, which was roughly 2 weeks after he entered the shelter, he had discontinued some of his behavioral manifestations of trauma and was mainly having difficulties coping and expressing his emotions. Because of the time frame of the trauma, I chose to utilize both nondirective and some semidirective techniques. Shin and Sink (2002) state that nondirective approaches may work well with children affected by trauma who are no longer exhibiting reactive symptoms, but who are having coping difficulties. Within a Jungian analytical play therapy framework (which combines nondirective, semidirective, and directive approaches, as described earlier), the therapist must accept three premises when counseling a child affected by trauma:

1. Each child has an unconscious psyche, and if the child is provided with a supportive and nonthreatening environment (or therapeutic "container"), it will reveal itself symbolically through spontaneous drawings, play, or dream content.
2. Though play, drawings, and dreams are not direct forms of communication with a child, they are valid and have meaning. They give the therapist a glimpse into the child's internal struggles.
3. The mind and the body are linked together, thereby allowing continuous communication between the two spheres—so that if something is troubling a child psychically, the body will communicate this, and vice versa (Allan, 1988).

Play Therapy Sessions

The play therapy sessions began shortly after I met Anthony and his family. Four of these play therapy sessions (sessions 1–3 and 5) took place in a makeshift play area (a storage room next to the kitchen area) inside the Red Cross shelter; the other four (sessions 4 and 6–8) were completed outside the shelter, at a picnic table near a lush green wooded area.

Sessions 1–2

The first couple of sessions consisted of building rapport with Anthony, which proved to be easy. For all of his parents' concerns and reports of his maladaptive behaviors, he appeared to be adjusting as each day passed. Upon entering the play area, I said to him, "Anthony, this is your play area while we are together. You can do most anything you want in here, except for hurting me or yourself. I'm just going to sit right here for now. When the big hand on the clock reaches the 12, our time will be finished." After I finished with this introduction, Anthony moved directly toward the art supplies, which consisted of plain white paper and sharpened pencils of various colors. Creative art work, including materials such as paper, colored pencils, glue, and paints, allow children to create freely what is going on in their lives (Furth, 1988) and to express themselves comfortably within the therapeutic dyad. Allan (1988) suggests that white paper be utilized in the playroom, to provide the children with a blank area on which to display their intrapsychic projections. As Anthony drew, I remained relatively quiet, not wanting to take the focus off his artistic creation. During play sessions, while the child is drawing,

> The counselor sits near or beside the child. The counselor does not talk much in the beginning stages unless the child initiates it. The counselor does not initiate conversation or take any notes, but observes the child, how the child approaches the drawing, the placement of figures and the types of images, symbols, and themes that emerge in the child's pictures. (Allan, 1988, p. 28)

In the first two sessions, Anthony spent approximately 15–25 minutes drawing scenes that looked very similar to each other. In the first drawing, the paper was largely covered by blue water, and within the water was a small ship that looked broken in half. There was also a small, dark shark fin in the water, and a bright yellow and orange sun at the top of the paper. I asked him if he could describe to me what it would be like if he was on the boat in the scene. He said, "It would be scary, 'cause it's sinking and everyone's gonna die." This scene provided me with a view of Anthony's internal world, containing themes of devastation and disaster. His response to the artwork and his affect while drawing seemed intense, reflecting the trauma's impact on Anthony's sense of stability and groundedness.

During the second session, Anthony drew nearly exactly the same scene, except that the black shark fin was larger and the sun had rays beaming from it, whereas in the first picture the shark fin was relatively small and the sun was a simple yellow circle filled in with an orange color. In an effort to amplify the symbols, I asked Anthony if there was any way the people in the boat could find a life raft or otherwise save themselves, and he responded, "No, the shark is going to eat them, and they will die in the water." All of this macabre imagery contrasted with the bright, shining sun at the top of the scene. Anthony was possibly struggling with ambivalent feelings, so I watched him as he reflected on the image and absorbed its beauty; then I placed the drawing in my file, and he left. Only after session 2 did I realize that the sun might be a source of healing for Anthony. His father had told me that he enjoyed playing soccer outdoors, and now this sun symbol was appearing in his artwork. Perhaps this could be a self-healing archetype, but I would not know until Anthony knew for himself.

Session 3

In the third play therapy session, Anthony repeated a scene similar to the ones he had drawn during the first two sessions, but this time with some interesting changes (see Figure 17.1).

Content of Session	*Rationale/Analysis*
THERAPIST: Anthony, you've really placed a lot of effort into this scene. I am impressed. (*Anthony looks up at the therapist for a second and smiles, then redirects his attention to the scene.*) I'm wondering if you could describe the scene to me.	I'm not praising the child, but praising his efforts here. By asking him if he can describe the scene, I am attempting to get an understanding of what he is trying to convey, and also to help him verbalize it so he can make the connections between his inner and outer worlds.
ANTHONY: Well, it's these people that are trying to get away from this shark (*pointing to the shark fin*). And the shark is trying to kill them, and he's fast. The boat is trying to get	In this scene, the boat is not broken in half, but intact. Also, Anthony has added sand at the bottom, which was not present in the first two scenes. The shark fin has shrunk slightly in size

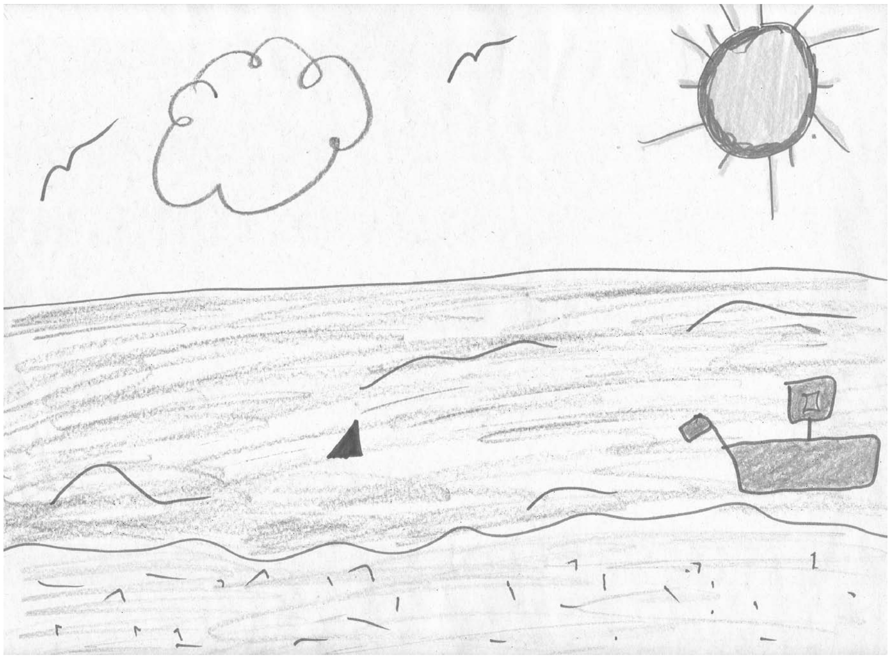

FIGURE 17.1. "The Flood"—Anthony's third depiction of a scene including a boat, a shark fin, and the sun.

away. But they're almost at the beach, so the shark can't get them there.	from the last scene. I get the sense while Anthony is talking that he is proud of his scene and in some way relieved that the boat is outrunning the shark to shore.
T: Ah, I see. I noticed in this picture that the boat is not broken in half or sinking like it was in the other scenes you drew. Do you know what made the boat be able to get away from the shark this time?	
A: (*Thinks for a minute and murmurs "hmm" under his breath as if contemplating.*) It's because the sun was out, and the wind was blowing, and the sail just could go faster. That's it.	Here he identifies the sun and wind as positive forces in the picture: They enable the ship to get away from the shark.
T: OK, Anthony. Thank you for sharing your artwork with me. If you could give a name to this picture, what might it be called? A: (*Without a second's hesitation*) "The Flood."	The title is important, as water is a theme that is recurring in Anthony's artwork, and also water is what nearly killed Anthony and his family as they were trapped in their attic. Here, his unconscious is attempting to make meaning out of the water and its devastating effects.

This drawing (Figure 17.1) seemed to reflect Anthony's slow progress toward psychic integration of the trauma. Specifically, the presence of brown sand, or earth, is a grounding feature of his third art scene. He commented that the boat is almost at the beach, where it is safe and the evil force—the shark—cannot harm the boat. And the sun is again present in this third scene, but this time it is more pronounced than in the first two scenes. In children's drawings, the sun can represent a healer, a restorer, or a provider of warmth and understanding for development (Allan, 1988; Furth, 1988). The ocean or water typifies primordial waters, which are the one of the four elements responsible for sustaining life. In a child's drawings, water can represent life and death, or can illustrate the vast, formless unconscious from which the child's nascent ego is attempting to regenerate itself. Anthony's drawing in our third play therapy session seemed to reflect the activation of a self-healing archetype—the sun shone brightly and guided the boat to shore, where safety from the dangerous shark awaited. In other words, Anthony's transference onto me was beginning to activate his feelings of self-acceptance and caring, which created new psychological maturation.

Sessions 4–8

For the fourth session, I asked Anthony if he would enjoy going outside in the sunlight to draw. He excitedly agreed, and I accompanied him to gain permission from his mother. The reasoning for this change in location was that I wanted Anthony to be able to reconnect to nature in some way—with the sun and greenery—in an attempt to continue his psychological self-healing. Nature was helping the boat in his artwork to escape from danger. As stated earlier, the Jungian play therapist believes in the mind–body connection; therefore, I viewed these series of images as Anthony's mind telling his body to reconnect to the outdoors with fresh air, sunlight, and the earth. Interestingly enough, Anthony's mother commented, "You know, son, you haven't been going outside much at all lately. You love to play outside. Go have fun."

During the fourth play session, Anthony and I sat at a picnic table—located adjacent to the shelter, in a small forested area with many large trees—and he drew another scene. This scene was basically the same scene as before, except this time the boat was located at the shoreline. Also, people appeared in this scene, all of whom were positioned in the sand. This scene contained a dark shark fin protruding from the water, as in the last few scenes. After he finished, I asked him how he felt as he was drawing. Anthony replied, "I don't know. I felt sad, but kind of happy. . . . I was sad 'cause I almost drowned in some water like these people in the boat, except there was no shark, just water and maybe an alligator. But I'm happy 'cause I like the beach, and I wish we had a boat so we could have gotten away from the bad storm." Here, Anthony was disclosing deep issues and fears as he began to trust more in me and the therapeutic relationship. This was the first time he had mentioned anything about his experience with Hurricane Katrina to me. With acceptance, I simply smiled and nodded my head to let him know that I supported him and was there for him. This drawing seemed to reflect competency and coping, as the people in the boat made it to shore and up onto the beach. The sun was present in this scene, a yellow mandala, which reflected the overall internalization of positive images. Later that afternoon, Belinda said that Anthony no longer woke up screaming in the middle of the night. I asked her if she noticed any other changes, and she said, "No, not really. Well, maybe he's talking more now, but I don't know if that's what you mean." Anthony was slowly emerging from his self-imposed exile.

The fifth session occurred back in the play area and consisted of Anthony placing his colored pencils in a circular shape, a mandala, on the floor (see my sketch of this in Figure 17.2). From a Jungian perspective, when a child draws or creates a mandala, it is representative of some type of psychic healing—the child's interior striving toward wholeness. According to Allan (1988), mandalas represent the Self in union with the ego. The circle represents the ego's boundaries, but refers to the Self at the same time in a state of congruence. Children's mandalas reflect the development of protective walls that function as an intrapsychic means of preventing psychological disintegration.

Without any probing, Anthony began to describe losing his mother at the convention center amidst the chaos of people. As he told me his story, I listened and did not interrupt or ask any clarifying questions. He talked about being terribly frightened; surprisingly, he explained that his fears were more directed about his mother's safety and personal well-being than with her not being there to

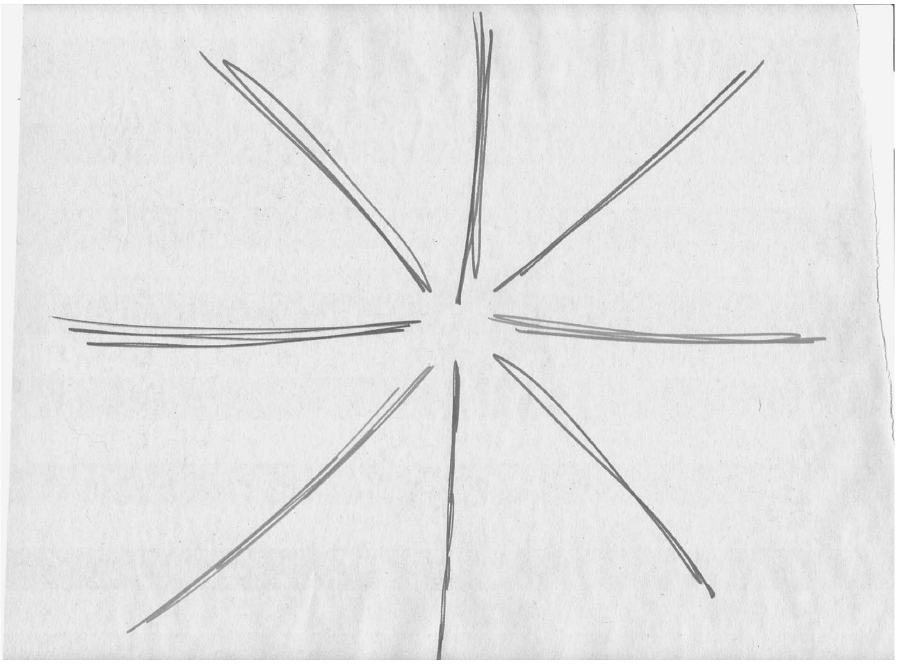

FIGURE 17.2. My sketch of the mandala Anthony constructed on the floor with colored pencils.

meet his own emotional needs. Anthony was ready to share his pain with me, and it was my responsibility in that moment simply to "meet him where he was" in the pain. After this session ended, we returned inside the shelter, and he ran to his mother and hugged her. I smiled and walked back to the play area to begin another session with a different child.

Our sixth through eighth play sessions were all conducted outside, with Anthony playing with a soccer ball while I mostly watched and tracked his play. He did not discuss his experiences during Katrina again. Anthony and his family were transferred to a shelter in a different city the day after our eighth session. Before they left, Anthony's mother gave me a hug, and Gerry and Anthony both shook my hand; Anthony was smiling, but looking reluctant to leave the shelter he had come to know as home for the past few weeks. I returned all of Anthony's artwork to him, and I directed him to think about the sun in his pictures when he was not feeling so good. He said, "Thank you," and left.

CONCLUDING COMMENTS

Throughout our time together, I believed in Anthony's psyche's ability to heal itself. We began play therapy by going "into the wounding" and ended by his initiating curative strategies for Anthony to heal himself. The life-threatening disaster and subsequent separation from his primary caregiver caused Anthony's deintegration of Self and fragmentation of his fragile ego. However, the therapeutic relationship engendered a sense of safety for Anthony to express his feelings and allow his unconscious to be represented and connected to his conscious. As he created and embraced the symbols, they transformed into affect. Instead of unconsciously repressing the haunting images and feelings associated with the trauma, Anthony's ego began assimilating the trauma by painting its image in symbolic form (i.e., the sinking ship hunted by the shark). By acknowledging the feeling and the image, Anthony was able to change his affect. The archetype of the Self guided Anthony where he needed to go. As his therapist, I was given a glimpse of where the Self led Anthony in the vast expanse of his underworld.

For Jungian analytical play therapy to be considered effective, the therapist must change just as much as the child. Both will influence each other; humanness is the critical point. Involvement of the therapist occurs on a continuum from active to passive, which influences the impact of therapy. A Jungian therapist might join in play, or accompany the child in his or her symbols and archetypal struggles in the underworld. Jungians possess a freedom to move along the therapeutic continuum by following the child and creating a safe space for the child's Self to evolve. In my work with Anthony, I found myself utterly struck by his resiliency and the power of his ego to reconstellate in the middle of such turmoil and psychic upheaval. As his ego became stronger, Anthony's behavioral impulses became less pronounced (i.e., his fixation with video games decreased, and his screaming in the middle of the night stopped).

Just as Anthony began to develop the skills to cope with the outside world, I noticed a transformation in my own coping style. I experienced initial trepidation about pushing children too far or not doing enough in disaster mental health work, and this fear at times consumed me. I coped with this fear by being hypervigilant and eschewing my inner guide. After I counseled Anthony, my coping style changed, because I realized just how powerful a child's Self is at inner healing and how little I needed to do. The symbols led brave Anthony toward his own inner healing. Therefore, I no longer maintained a heightened level of psychoarousal, and I trusted myself more in the process. Just as the alchemists attempted to transmute lead into gold, I noticed a calming within me that converted my irrational fears of inadequacy into a modest self-assurance. I believe this had a positive effect on children in that the process of therapy seemed to flow more naturally from then on.

Study Questions

1. Do you think that cognitive-behavioral play therapy or a more directive approach would have brought about a different outcome for Anthony? Discuss with details.
2. In Jungian analytical play therapy, how does the therapist guide the child toward archetypal self-healing?

3. If you were Anthony's therapist, at what point might you have involved the mother or conducted family counseling? How would you address the trauma of family separation?

ACKNOWLEDGMENTS

To those whose lives have been permanently affected by Hurricane Katrina, I wish you solace as you find your way Home. I would also like to express my sincere gratitude to everyone who supported the Johns Hopkins University Play Therapy/Mental Health Initiative, and especially Jennifer Baggerly, Glenn Doucet, Ralph Fessler, Kristi Gibbs, Jennifer Gloscof, Alan Green, Barbara Hebert, Reese House, Wallace Kahn, Vivian McCollum, Paul Metrejean, Kit O'Neil, St. Landry Parish School Board, and Heather Tracy for rekindling hope in children when there was no hope to speak of.

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Chapter 18

Sudden Death of a Parent in a Terrorist Attack

CRISIS INTERVENTION CONJOINT PLAY THERAPY WITH A PRESCHOOL BOY AND HIS MOTHER

Nancy Boyd Webb

The events of September 11, 2001 have been permanently etched on the memories of all who were in the United States on that fateful morning. At the time this chapter is being written (approaching the fifth anniversary of those terrible occurrences), a newly released movie, *World Trade Center,* focuses on the families of two firemen in New York City who came close to dying in the process of trying to rescue some of the thousands of people trapped in the Twin Towers of the World Trade Center (WTC). Although the heroes in the movie ended up being rescued themselves, few were as fortunate in real life, according to statistics about the numbers of fatalities.

The online version of *New York* magazine reported that in the WTC attacks, 1,609 people lost a spouse or partner and 3,051 children lost a parent ("The Awful Numbers," 2002). The ratio of men to women who died was approximately 3:1, and the average age of the 2,819 who died was between 35 and 39. Thus most of these traumatic deaths occurred to men in the prime of their lives, many with wives and young children who then had to deal with the unthinkable question of how to carry on without the guidance, love, income, and protection of their husbands and fathers.

This chapter presents a single case in which a father/husband died in the attacks on the WTC. The example demonstrates the use of a form of crisis intervention play therapy in which conjoint treatment with a 4-year-old boy and his mother helped improve their relationship even as it encouraged a mutual grieving process. Developmental issues in bereavement are emphasized, including both preschoolers' typical levels of understanding and predictions about this child's future adjustment to the absence of his father over the course of his childhood and adolescence.

FATHER LOSS IN THE PRESCHOOL YEARS

Young children rely on their parents for their survival, safety, love, and feelings of well-being. The untimely death of a parent when a child is still growing deprives him or her of a primary source of attachment, socialization, and companionship. When the parent who dies is the same gender as the child, the youngster also loses a major role model and guide in the process of becoming a male or female.

Developmental Considerations

Attachment and Loss

Biologically driven atachment responses are universal among humans, and they exist for the purpose of providing infants and young children with protection and security. The hallmark of attachment is proximity-seeking behavior, which a toddler achieves by staying close to the important people in his or her life. The typical preschool child has multiple attachments, with the mother generally serving as the primary attachment figure, while the father and other regular caretakers may function as secondary attachment figures (Davies, 2004). As the child gradually develops the ability to form a mental representation of significant people ("object constancy"), he or she begins to be able to regulate anxiety without immediate help from a parent (Davies, 2004). However, this progress is sporadic and subject to reversal under stressful conditions: The young child who is upset or frightened quickly reverts to wanting to be close to a parent for comfort and security. When an attachment figure disappears from the child's life because of death, the youngster may experience intense feelings of distress, confusion, anger, and separation anxiety.

As noted earlier, this chapter focuses on the reactions of a 4-year-old boy to the sudden, traumatic death of his father. Although the example here involves a death in a major terrorist attack, similar dynamics would prevail for a child and family in other situations of sudden parental death. Therefore, the theoretical and treatment implications of this case are applicable to such deaths caused by a variety of unpredictable situations, such as motor vehicle accidents, war, natural disasters, and urban shootings. An understanding of the specific impact of any loss requires an assessment of the child's and family's circumstances prior to the death, and this is discussed later in this chapter. However, with reference to preschoolers in general, we know that during early childhood young children begin to develop their gender identity, and that the process of "identification with parents becomes a primary means of defining the self' (Davies, 2004, p. 301). Therefore, when a male preschooler's father dies, that child loses not only a parent and an attachment figure, but also an important identification model (Chethik, 2001). In Western cultures, the father's role with children of either gender often consists of play interactions that encourage the child's exploration of the world (Grossmann, Grossmann, & Zimmermann, 1999). With this in mind, some regression to earlier developmental stages could be anticipated following the death of a child's father, with possible hesitancy on the child's part about engaging in new activities in the future.

The Preschooler's Understanding of Death and World Events

Children's understanding of death parallels their cognitive development. As I have reviewed previously (Webb, 2002), the concepts of the permanence, irreversibility, and universality of death develop gradually over time. The preschool child believes in magic and typically has an exaggerated view of his or her own power. Piaget (cited in Davies, 2004) called the preschool years the "preoperational" stage, and described this stage as characterized by the child's inability to discriminate between thoughts and deeds. This combination of egocentric and magical thinking makes most preschool children unable to fully comprehend the reality and finality of death. In addition, they cannot understand causality and have a very literal and sometimes distorted view of how and why a particular death has occurred. Many young children are afraid of death, and may try to master their fears through magical means, such as by wearing a skeleton costume at Halloween or by holding their breath when passing a cemetery. When a preschooler comes to realize that no amount of magic or ritual will bring a dead father back, the child may become very confused and angry.

Cultural, religious, and family beliefs influence how a family responds to a death and whether or not the children are included in various ceremonies. For example, therapists working with bereaved Christian families need to be alert for preschool children's possible misconceptions regarding their families' beliefs and teachings about heaven and God. It is very difficult for a preschool child to comprehend the distinction between the body and the spirit, and when he or she hears a minister or priest say, "God wanted your father and took him to heaven," the child may begin to resent God and/or to wonder whether and when it might be possible to travel to heaven to pay a visit to the dead parent.

The traumatic deaths of 9/11 involved not only the tragedy of mass destruction and multiple deaths, but the additional complicating fact that these were caused deliberately with the intent to bring about the maximum of psychological, economic, and physical distress to the citizens of the United States. Because of the uncertainly in the aftermath of the attacks about the possible recurrence of similar destructive events, many adults lived in a state of anxiety and fear for several months, not knowing what might happen next or whether they or their children would ever be safe again.. This seriously and negatively affected the ability of parents to comfort their children and reassure them about their safety (Webb, 2004).

Many children watched television replays of the attacks on the Twin Towers, not fully understanding that the events were not recurring over and over. Parents and teachers struggled to figure out what and how much to tell the children about the perpetrators. Guidelines posted on the Internet at the time (and subsequently updated) recommended that parents relay to their children the limited information known at the time about the event and the perpetrators, while also trying to reestablish the children's usual routine as much as possible (National Center for Child Traumatic Stress Network, 2006; Brymer et al., 2006). At that time, however, no one could guarantee safety to anyone, due to fears about repeated future attacks. In addition, the lives of the several thousand children whose fathers never came home were changed forever, and it must have been extremely difficult for their surviving mothers to muster the emotional resources to carry out these guidelines.

Mediating Factors

Critical Role of the Surviving Parent

Numerous articles and chapters in the professional literature emphasize the importance of surviving parents' being able to deal with their own traumatic grief in order to be able to support their children (Osofsky, 2004; Rossman, Bingham, & Emde, 1997). According to Van Horn and Lieberman (2004, p. 118),

> the caregiver's capacity to cope with a child's response after a trauma has been found to be the strongest predictor of child outcome, with increased levels of maternal support predicting lower levels of symptomatology and higher levels of adjustment in children. . . . When young children suffer traumatic life experiences, the best way to ensure their return to a positive developmental trajectory is to enhance their caregivers' capacities for care and empathic responding.

This wise principle was very difficult for the many traumatized mothers whose husbands died in the WTC attacks to put into practice. Some bodies were never positively identified, leaving families without the closure of a funeral and with lingering hopes that their loved ones might be found alive at some future time. In addition to being suddenly thrust into the single-parent role, the mothers were uncertain about their own ongoing safety and lived with continuous fears about potential, unknown danger.

Influence of Extended Family and Community Supports

In the immediate aftermath of 9/11, most people went to great lengths to obtain physical proximity to their loved ones, and to establish telephone contact with extended family members who lived in other areas of the country. The attachment responses of both children and adults were triggered, as families tried to stay together as much as possible. The role of the extended family in providing comfort and support was especially strong in families that suffered a missing person or a death. Families always tend to come together at times of bereavement, but this situation of national bereavement added a further layer of grief on top of their personal loss. Because this tragic event affected so many people, there was an outpouring of helping efforts in the community and from the nation. This kind of mass mourning and support may have been quite meaningful to adults, but probably was irrelevant to the young children who were reacting to the personal loss of their fathers or mothers. Another source of stress for these bereaved children was the threat of unknown danger. Fletcher (1996) has pointed out that as children age, their ability to comprehend danger increases. For those children who were told that the "bad guys killed your daddy and a lot of other people," the world must have taken on a very dangerous ambiance.

CHILDREN'S TRAUMATIC GRIEF: TREATMENT CONSIDERATIONS

Traumatic grief differs from ordinary bereavement, because the element of trauma overpowers and interferes with normal grieving (Cohen, Mannarino, & Greenberg, 2002; Pynoos, 1992). As a result, components of the trauma must be addressed before the individual can focus on and process his or her grief (Webb, 2002; Nader, 1996, 1997). Some specific treatment techniques intended to help a child deal with traumatic memories, so that he or she can move on to grief processing, include the following:

- Stress management exercises, such as relaxation, guided imagery, safe-place drawings, or age-appropriate deep breathing exercises (e.g., asking the child to pretend to blow up a balloon or blow bubbles).
- Psychoeducation about typical reactions to trauma (e.g., "It's OK to be scared and to have bad dreams; you'll feel better after a while").
- The creation of a story about the traumatic death ("the trauma narrative"). This is done gradually, at the child's developmental and tolerance levels, over several sessions. Sometimes the child draws a picture of the trauma, and other times he or she may use dolls and other toys to recreate it.
- Correction of inaccurate cognitions (such as guilt about what caused the death, and/or how it might have been prevented).
- Encouraging a pretruama (intact) memory image of the deceased. This may be accomplished by looking at old photographs that stimulate positive memories.

All of these approaches require great sensitivity on the part of the therapist, in order to avoid flooding the child with anxiety related to the trauma and with feelings of grief about the loss. The timing and pacing of the work will vary, depending on developmental factors and on the child's ego strengths and coping resources (Crenshaw, 2006). The therapist must move carefully between activities that generate anxiety and those that help to contain it. After the child has begun to attain some distance from the trauma, and to put it clearly in the past, he or she may begin the mourning process. For example, this may occur through looking at old photos that engender feelings of sadness because the person is no longer present, with wishes that it could be possible to see the deceased family member again (Klass, Silverman, & Nickman, 1996).

Evidence-Based and/or Evidence-Informed Treatment Options

To date, relatively few scientifically rigorous child treatment studies have been conducted following disasters and other traumatic events (Cohen, 2003; O'Donohue, Fanetti, & Elliott, 1998; Saunders, Berliner, & Hanson, 2003; Shelby & Felix, 2006). At this point, many studies of the effectiveness of different therapies in reducing child trauma symptoms favor the use of cognitive-behavioral therapy (CBT) over other methods. However, it seems interesting that CBT-oriented researchers have conducted most of the existing comparative research (Shelby & Felix, 2006). Possibly because the goals of CBT are so specific, they lend themselves more easily to measurement. I have argued earlier (Webb, 2006) that the fact that other child treatment approaches, such as play therapy, have not been studied in comparable controlled outcome research does not mean that this and other treatment methods may not also help traumatized children.

Authors of treatment reviews always conclude that more research is needed, but I would further urge that this research should be informed by the experience of clinical practitioners. Each group (practitioners and researchers) in the mental health field must devote more attention to the activities of the other, so that we can all be assured that current practice has a basis in both scientific study and in clinical reality. "Anecdotal" reports and single-case studies can serve as a starting point for research that is grounded in practice validity. Meanwhile, given our current lack of definitive research results about evidence-*based* practice, some child therapists are using the terminology "evidence-*informed* practice." This suggests that while conclusive findings are still lacking, some approaches seem to look promising in terms of practitioners' and clients' satisfaction with the outcomes.

Cognitive-Behavioral Therapy

As previously mentioned, CBT methods have reported high levels of success in the treatment of traumatized children and adolescents. The early work focused on young victims of sexual abuse (Cohen & Mannarino, 1993, 1996). This approach actually merged play therapy methods such as the use of dolls, puppets, and art with cognitive techniques such as thought stopping, cognitive reframing, positive imagery, and parent training in a short-term (12 session) model that brought about significant symptom improvement. Neubauer, Deblinger, and

Sieger (Chapter 6, this volume) describe this approach in detail with a young child victim of sexual abuse and witness of domestic violence. CBT-oriented researchers have now developed a model to treat traumatic grief in children (Cohen et al., 2001). Some of the key elements in this approach involve the use of typical cognitive techniques, such as relaxation methods, increasing the individual's sense of safety, increasing his or her ability to discuss the traumatic death without extreme distress, and correcting any misconceptions about the trauma.

Eye Movement Desensitization and Reprocessing

Some researchers studying the efficacy of various treatment approaches for trauma have found eye movement desensitization and reprocessing (EMDR) to be "at least equal" to CBT in efficacy and acceptability (Greenwald, 2006, p. 251). However, there is not much research on the use of EMDR with children, and practitioners who wish to use this method must first receive extensive training at a postprofessional level. Some illustrations of cases of children who were helped with EMDR appear in Greenwald (2006), in Lovett (1999) and in Tinker and Wilson (1999).

Crisis Intervention Play Therapy (CIPT)

This short-term directive approach incorporates elements of CBT-oriented play therapy and psychodynamic play therapy. Numerous anecdotal reports attest to the treatment effectiveness of crisis intervention play therapy in helping traumatized children (Brohl, 1996; Shelby, 1997; Webb, 1999, 2002, 2006, and Chapter 3, this volume). The rationale of CIPT is that early intervention will bring relief before the more intractable symptoms of posttraumatic stress disorder or other diagnosable mental disorders develop (see Nader, Chapter 2, this volume).

Conjoint Parent–Child Therapy

Therapy with a parent and child together is referred to as "conjoint therapy." The focus of such therapy is on the parent–child relationship and how to improve it. The following case example demonstrates conjoint play therapy with a traumatically bereaved mother and her preschool son.

THE CASE: BRETT, AGE 4, AND HIS MOTHER, DIANE

Presenting Problem: Referral Information

The referral was made in April 2003 by a hospice art therapist, who stated that a mother needed help to manage her 4-year-old son, because he had been "horrible with his mother" since the death of her husband in the WTC attacks on 9/11. The mother had been participating with two of her older children in bereavement groups at a local hospice since November 2001.

At the time, I had a small private practice (in addition to my university affiliation) in a community about 25 miles north of Manhattan. I was known among professionals in the community as a child and family therapist with a specialty in bereavement and trauma.

This referral was made about a year and a half after the tragedy of 9/11. The mother has given me signed permission to write about this case for the purpose of training other practitioners. Nonetheless, I have disguised all names and some other details, to protect the confidentiality of the children.

My usual procedure is to see a parent first to obtain background information about the family and the problem situation, to create a genogram of the family, and to establish a relationship with the parent. I was very aware that this mother had gone through a traumatic bereavement experience, as had the entire family, and I found myself wondering how she was managing after such a terrible loss. The family information that follows is what I collected at the time of intake.

Family Background

Gerry: Age 37 (when he died); commodities broker; worked on 92nd floor of Tower 1
Diane: Age 39; not employed; background in retailing
Jenny: Age 8½; third grade; good in school; reserved; "likes to please"
Christy: Age 7; first grade; very verbal; "smart and tough"
Brett: Age 4; preschool, mornings (started last year, took 2 months to adjust)
John: Age 1; "sweet"; some chronic ear problems

Kate: Age 31; sitter, 40 hours per week; slept over three nights a week

Extended Family Background

Paternal grandparents: Lived in Georgia; not much contact
Gerry's two brothers: Both married and living in upstate New York
Maternal grandparents: In early 70s; living in upstate New York
Diane's brother, Bob: Married and living in upstate New York
Diane's sister, Susan: Married and living in upstate New York
Diane's sister, Angie: Not married and living in New York City

The maternal grandparents had bought a second home upstate for Diane and her children after Gerry's death, and the rest of Diane's family went there frequently for weekends and vacations. Brett was extremely close to his maternal uncle, Bob, who spent a great deal of time with him during these family get-togethers.

The whole family was Catholic, and the children attended Catholic schools. Gerry's remains (see below) were buried in a Catholic cemetery in upstate New York.

First Session with Mother

Diane was a very attractive woman who appeared to be managing quite well in the situation of being suddenly left a widow with four children. When asked to tell me about Brett, Diane said that he was getting very "rambunctious" with her. He was very strong physically, and he was starting to hit her. He had also learned about guns about 3 months ago, and since then he had been getting quite excited about war. Diane said, "He is very loud; I can't stand to be with him." When I asked whether things had always been like this, Diane said that Brett used to be a "good boy," but that for the past year and a half he had definitely been getting worse. (Note that during this period Brett's father had died tragically, and his mother had had a baby 4 months later.) Diane stated that Brett had no problems at school and that he got along very well in a one-to-one situation.

When I asked about Brett's previous relationship with his father, Diane said that they had been very close; her husband took Brett every place with him on weekends, and he was always home around 4:30 on workdays, so he saw a lot of the children at the end of the afternoon.

I mentioned that Brett must miss his dad a lot, and Diane said that he talked a lot about "the bad guys," referring to the terrorists who attacked the WTC. When I asked whether they had recovered Gerry's body, she said that they had received a few body fragments, and that they had had a memorial service for him 10 days after the attacks. She did not want to go to the site of the Twin Towers; nor did she attend any of the large community memorial services for those who died on 9/11. However, she did participate in a support group of 9/11 widows every other week, and she had gone regularly to the hospice bereavement groups since November 2001 with Jenny and Christy. Brett was about to begin a group at the hospice.

I gave Diane some guidance about how to prepare Brett for coming to see me, and told her that she would be welcome to stay in the session with him if she and he wanted this at the time.

First Session with Mother and Child Together

Brett was a husky, handsome boy 4 years and 3 months of age. He alternated between clinging to his mother and playing enthusiastically with blocks and other toys.

Content of Session	*Rationale/Analysis*
THERAPIST: I'm so glad to meet you, Brett! Your mom was here before, and she told me about you and your family.	I am trying to establish some credibility.
BRETT: (*Looks to Mom for confirmation.*)	
MOM: Dr. Webb helps kids and families like us.	

T: Sometimes we talk, and sometimes we play. Would you like to make a drawing? (*Hands Brett some colored paper and markers.*)	
B: (*Immediately begins drawing, using red and orange, and ends with a lot of heavy coloring over one section* [see Figure 18.1].) I'm done.	Does the scribbling indicate anxiety? Or blood?
T: Can you tell me about your picture?	
B: It's a design. (*Looks around for something else to do.*)	It's too soon for any details.
T: (*Brings out a dollhouse, furniture, and family dolls.*) You can set this up any way you want.	
B: (*Puts the furniture in the various rooms, then puts a toy fireman figure in the bed; other people are in different rooms.*) Now all the furniture is going in the Dumpster. (*Takes it all out of the house and throws it on the floor. Then he finds small toy police cars and fire trucks, races the cars and trucks up to the house, and throws all the people from the house on the floor.*) They're all going to die. I'm done.	Destruction of a family home, and then destruction of the family. Wonder how Mom feels about all this?
T: (*Takes out a big bag of blocks.*) Why don't you and your mom make something together?	Can they work together?
B: Like a house?	
M: He never likes it how I do it.	Is she intimidated by him?
T: Why don't you try to work together? (*Mom gets down on the floor with Brett. They build a structure, using all the blocks.*)	

FIGURE 18.1. Brett's drawing. "A design."

B: It's going into a Dumpster and be a wreck.	He is showing me his destroyed life. I feel sad.
T: That's too bad!	
B: They're all dead. The bad people are in hell, and the angels are in heaven.	Religious teachings.
T: We can make another one. (*Gets down on the floor and builds another structure; Brett closes his eyes for a minute.*)	I am trying to offer hope.
B: I'm done. (*Moves close to Mom and tries to hug and kiss her.*)	He's looking for reassurance.
M: It's time to leave. We need to help Dr. Webb clean up.	

Comments on First Session

The themes of death and destruction were very evident in this child's mind and in his play. I sensed some tension between mother and child. Diane tried to participate, but seemed to hold back. Brett obviously wanted reassurance from her, but she was not particularly responsive to his needs. I decided to proceed with conjoint therapy for the time being, rather than to set up individual play therapy sessions for Brett.

Second Session with Mother and Child

Content of Session	*Rationale/Analysis*
Brett: (*Comes in smiling and carrying a big backpack.*)	He is handsome and cute.
Mom: I'm very angry with him. I don't know if I should be here or not.	She is furious!
Therapist: You both know that I'm a "trouble doctor." If you're having troubles, this is the place to be. (*Mom sits on the couch, and Brett leans on her, molding to her body and smiling; she tries to move away from him.*)	She'd like to have me fix him without including her. He doesn't seem aware of his mom's anger.
M: Brett was sick and stayed home from school. He spent the day screaming, and he kept poking and annoying the baby. I have a chart, and he gets chips for good behavior; he has nine chips, and if he gets one more he'll get a reward. He didn't get any chips today, though!	Sounds like a behavior modification chart. She is trying to motivate him.
B: I want to make a Mother's Day card. (*Therapist gives him paper and markers; Brett makes two cards, one with a volcano.*)	The symbolism is apparent.

Diane mentioned taking Brett to the car wash and the hardware store this past week. She recalled how he used to love to go both places with his dad. I asked them to bring in photos of Dad next week, and Brett said he thought he had a photo in his backpack; Diane couldn't find it. Then he asked if she had a picture of his father in her wallet, and she said she didn't. She said they would bring a picture next week.

Comments on Second Session

This boy seemed to be very needy. He was very bright, and he craved love and attention from his mother, especially since he had now lost his favored position with his father. It's not clear whether he had seen pictures or videos of the destruction of the WTC. He seemed to create this symbolism in his play, however.

Diane appeared to be quite "strung out." Taking care of four children seemed to be stretching her emotional capability, even with a nanny. She seemed to want Brett to be more mature than he was capable of being. I was convinced of the validity of continuing the conjoint sessions.

Assessment and Treatment Plan

A year and a half after 9/11, this child was still living in the same home as before his father died. Nonetheless, he seemed torn between his anger toward his mother and his need for her comfort. The anger might be related to the facts that his father had "left" the family, and that now his mother seemed somewhat depressed, emotionally distant, and unable to give him the comfort and affection he needed.

I hoped that the conjoint sessions would permit this boy to express his anger, and that the time alone with his mother would prove beneficial for both. Clearly, the mother's grief also needed to be expressed; I hoped that this would be addressed in the hospice group for bereaved parents.

Goals of Treatment

The primary goal of treatment was to improve the parent–child relationship. This would be addressed by helping the mother take pleasure in her son's very appealing qualities, and helping the two to find mutually satisfying activities in which to engage together.

A secondary goal of treatment was to identify possible signs of traumatic grief in either the mother or the son, and to permit the expression of such grief either verbally or in play. Brett, as a preschool child, might not comprehend accurately the circumstances of his father's death. Any confusion should be clarified with facts; the boy's anger should be permitted in play, but not in interpersonal actions.

Overview of Treatment

The sessions with this child and his mother occurred in two time periods. The first period was between April and June, when school ended and the family moved to their vacation home for the summer. There was no contact during July and August. The second treatment period began once school had started and the family moved back to their usual home. There were weekly contacts from September to December. After Christmas, I initiated a 2-month between-semester break. There had been considerable progress in meeting the goals at this time, and when I called Diane in March to see if she wanted to resume treatment, she reported that things were continuing to go quite well; she thought that there was no further need for treatment.

Summary of the April–June Sessions

From April to June, there were seven conjoint mother–child sessions and one session with the mother alone. During almost every session, Brett would build houses with blocks and then destroy them—either by "throwing everything into a Dumpster" (his expression) or saying that the people all burned in a fire. He also would usually ask to play with my Fisher-Price dollhouse, and typically after setting it up with furniture and people, he would either throw the furniture and people out or say that the house was burning in a fire. He used firemen toys and fire trucks often; one time I asked him if he had seen firemen in the WTC, and he responded that "they were all inside." On one occasion he said that he wanted to make "my (e.g., his own) house" with blocks, and then he furnished it with the furniture from the doll house. He put the mother and father dolls in the large bed and the little boy doll between them, and then put two girl dolls in separate twin beds. He smiled and said, "That was when it was good!" (Obviously he was recalling a positive memory.) Immediately afterward, however, he said, "the girls got dead," and he threw everything "into the Dumpster."

In a session alone with Diane, she admitted that she got furious with Brett because he did destructive things such as cutting her azalea bushes. She compared herself to the other mothers in her support group and confessed that, unlike them, she did not find joy in her kids; rather, she felt a sense of heavy responsibility and obligation. She knew that Brett wanted more from her than she could give. I agreed that he seemed to want and need a lot of reassurance from her, and I normalized this in terms of his probable fear that she might die and disappear from his life also. I suggested that she could help him by setting aside some time alone for him, and that as a result, he might become less demanding. For example, she could tell Brett that coming for therapy was "his special time with Mom."

In the following two sessions with Brett, Diane brought photos of her husband with Brett. In the first, Brett was about 1½ years old and sitting on his father's shoulders. This must have been about a year before 9/11. Brett said he could remember it, but thought that he was 2 years old then. The second picture was of Gerry standing alone in front of the Twin Towers. Brett was more calm than usual during these sessions. He put his head on his mother's lap and smiled; he still made houses with the blocks, but did not destroy them. It seemed to help him when his mother made it possible to remember and talk about "the good times."

Comments on Spring Sessions

There was a definite change during this period from the earlier repeated death reenactments to calmer, less pressured play. The mother, although still feeling overwhelmed by her son's energy, became more able to focus on him and to participate with him in his play. I believe that they both were benefiting from the hospice groups, and that the conjoint treatment gave them very valuable time alone together. When we said goodbye for the 2-month vacation period, I felt that Brett had experienced some cathartic relief in playing and replaying his death scenes; equally important was that the parent–child relationship seemed warmer and more mutually satisfying.

Summary of the September–December Sessions

Brett eagerly resumed his play as he had left it, and in the first session after the summer break, he asked for "that house" (the Fisher-Price dollhouse). He began with some positive play themes, creating "gifts" out of the toys in my office and wrapping them up with colored paper and Scotch tape. He asked for his mother's help during this play, and she participated according to his directions.

At one point, Diane told me that they had gone to visit the cemetery on Father's Day, and this seemed to precipitate for Brett a return to his stories about death. In making up a story during a storytelling card game, Brett created a family with no toys and no clothes, and then said, "They're dead." He then quickly stated, "It's pretend."

Other repeated themes and statements included the "bad people," towers falling on police cars, "making them all die," and people who died in a fire. Clearly, this child continued to need to play out traumatic death scenes as he imagined them to have occurred. My role during his play was either to comment on what he was doing (i.e., to make tracking statements) or to express feelings of sadness and fear. Diane seemed to watch and listen, and when asked by Brett to do so, she participated in his play.

Beginning in December Brett began to bring toys from home; these were usually cars, and one time he brought a big fire engine. The play began to take on a calmer quality. In mid-December, Brett brought in a personal book he had created in school about his life. It had several pictures of his father, as well as other family members. He was proud of this project and wanted to share it with me. I mentioned that I was glad he had such wonderful photos of his dad, because these would help Brett remember him.

Diane continued to show much more patience with Brett. He was very independent; she waited for him to ask for help, and then let him direct her involvement.

Summary of Fall Sessions

There was continued improvement in the parent–child relationship. Brett continued to express the death themes, but not every session. I believe that he was acting out repeated situations of sudden, traumatic deaths in which some people died in fires. Considering that he was only 2½ years old when his father died, developmentally he was struggling to comprehend the meaning of death, and the repetitive play might be helping him begin to fathom what happened.

Telephone Contact after the 2-Month Break

When I spoke with Diane by telephone after the between-semester break, she said that things had been going pretty well. She remembered that I had said that Brett wanted more time with her, and she had been deliberately trying to arrange this. She said that he still had occasional outbursts at home, but these were less frequent than before. He loved the hospice group and wanted to continue in it, even though his sisters wanted to stop. Diane said she would continue to take him to the group as long as he wanted to go. She saw no reason to resume treatment at this time.

Follow-Up 1 Year Later

I contacted the mother a year later to request a meeting to discuss how Brett was doing, and to ask her to sign the release form permitting me to write this chapter. I also mentioned that I would like to ask a few questions to help me clarify some details. Diane was most willing to meet with me, and she answered all my questions fully.

When we met, she said that Brett was doing well in school: “His teachers love him and say that he is a leader.” He continued to benefit from the interest and involvement of his Uncle Bob, who took him boating and gave him a lot of attention when the family was upstate in the summer. One time Brett had asked Diane if she would ever get married again. Diane said, “Maybe,” and then Brett asked if that meant he would call this man “Daddy.” Diane wisely said that this would be up to him. Diane also mentioned that Brett always seemed attracted to older boys and men, and she realized the meaning of this. She had begun dating, but said that it was “not serious”; she added that she had not brought anyone home or introduced anyone to the children, and would not until she became “serious” about the person.

The photo Diane brought of her and the children showed them in front of a big sign with her husband's name on it. She explained that the small community where she lived had named a park in Gerry's honor, and that her kids referred to it as "our park." This recognition was gratifying to the whole family. I asked how often Brett spoke spontaneously about his father, and she said that this probably happened two or three times a month. He sometimes drew pictures of the Twin Towers with his smiling father in the picture (this reminded me of the photo they had shown me previously). They had lots of photos of Gerry in every room in the house, and they celebrated Father's Day each year by going to the cemetery and lighting a candle.

The children no longer attended the hospice program, and Diane's support group of widows was now meeting only once a month and would probably end soon. The family members were all obviously carrying on with their lives, and Brett seemed to have resolved his intense anger over his father's death and his mother's unavailability.

CONCLUDING COMMENTS

This case illustrates the value of conjoint parent–child treatment in a situation of traumatic grief that resulted in the surviving parent's inability to meet the needs of her preschool child. Because of the critical importance of a mother's ability to help her children during the bereavement process, conjoint crisis intervention play therapy proved to be the treatment of choice in this situation; it resulted in a reduction of the boy's problematic behaviors and a greatly improved mother–son relationship. Due to the fact that this treatment occurred a year and a half following the trauma, it did not strictly meet the criteria for "crisis intervention," which typically is offered soon after the traumatic event. However, the mother–child relationship was clearly in a crisis state at the beginning of treatment, and it is possible that without therapy, the boy and his mother would have grown farther apart and the boy's anger might have begun to spread to his other relationships.

This child's play therapy demonstrates how a preschooler will repeatedly "play out" his or her confusions in an attempt to comprehend a traumatic event and reduce anxiety. Brett would himself put boundaries on his play by saying, "I'm done," thereby preventing exploration for which he was not ready. Follow-up with the mother some time later indicated the boy's continued positive functioning, although the likelihood of future difficulties remains, due to increased challenges over the child's developmental course. This family clearly had many resources, both financial and emotional, and the mother was open to obtaining help for both herself and her children. The challenges for boys growing up without a father *can* be met through play therapy and through resources in the family and community environment that help to enhance the natural resiliency of children.

Study Questions

1. Discuss factors other than Diane's grief that may have had an impact on her relationship with Brett. Consider the boy's temperament and gender in your response.
2. Compare and contrast the use of conjoint parent–child therapy with the use of family therapy in situations of traumatic bereavement. Do you think that the entire family should have been seen? Or that subgroups of the family should have been seen? What factors would determine the therapist's decision? Role-play an initial family session, with all family members present.
3. Consider the issue of secondary traumatization as it may have affected the therapist in this case. How can the therapist guard against becoming preoccupied with a case involving traumatic bereavement?
4. At what age do you think it is appropriate to engage a child and parent in conjoint therapy? The intake information stated that Brett had been having difficulties for a year and a half. Do you think that it would have been helpful to have begun therapy sooner? If so, at what age?
5. Discuss the developmental factors that apply to boys whose fathers die when they are preschoolers. What predictions can you make about Brett's future ability to cope without a father?

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Chapter 19

Multiple Traumas of Undocumented Immigrants—Crisis Reenactment Play Therapy

CASE OF XIMENA, AGE 12

Rowena Fong
Ilze Earner

The population of undocumented and illegal immigrants in the United States is growing, despite the U.S. government's strong and persistent efforts to increase border security and tighten legislative policies. The attempts to crack down on this population are affecting children and families who are struggling to survive. As Delgado, Jones, and Rohani (2005) state, "It is important to reemphasize that the difference between a refugee and an immigrant or undocumented person may have more to do with the political situations of the United States than any other factor" (p. 18).

The situations of these families vary, but most of them have endured multiple traumas. Many of the families are leaving countries where economic conditions have forced them to think of an alternative country to live so they can feed their children or make decent wages; they hope someday to become legal, permanent U.S. residents. Other families have decided to leave countries where political and/or religious strife has created a hazardous, war-torn environment. Desperate to leave their countries of origin, these families either may be smuggled into the United States or may have legitimate documents when they leave their homelands. However, even those who initially entered through legal means may later be designated illegal and no longer have valid documentation to stay in the United States. Still other people, such as students, tourists, or businesspersons, may initially come to the United States with legal documents but overstay the length of their authorized time visits (for various reasons), thus losing their legal status and privileges. Their skill levels and needs will be very different from those persons who are illiterate and without employment experience or skills. Because many different types of situations cause undocumented persons to come to the United States, it is very important for social workers, counselors, and therapists to know the circumstances and conditions in which such children and families come for help.

The literature on immigrants and refugees is beginning to include works that focus solely on undocumented individuals and families (Delgado et al., 2005; Foner, 2001; Fong, 2004; Potocky-Tripodi, 2002). In adding to this literature, this chapter begins by covering the issues of multiple traumas experienced by undocumented families at different stages, manifestations of trauma in undocumented children, and crisis reenactment play therapy. A case of a 12-year-girl in an undocumented family is then presented, with highlights and concluding comments.

TRAUMAS OF UNDOCUMENTED FAMILIES AT DIFFERENT MIGRATION STAGES

Undocumented individuals and families endure multiple traumas, which take a lot of time and patience to work through in therapy. The traumas may be related to what they endured in their homelands, what they experienced in their journeys to America, and/or what they are subjected to when they make adjustments to living in the United States (Balgopal, 2000; Fong, 2004; Webb, 2001). Zuniga (2004, pp. 186–187) describes the five stages of migration originally outlined by Sluzki (1979); although these five stages do not pertain specifically to *illegal* migration, they provide a framework that can help professionals determine the nature and extent of traumas endured by undocumented individuals and families.

Stage 1 is the "preparatory stage"—a time when a person or family makes the decision to leave the homeland. For some people, this decision is carefully planned, with thought and consideration of all family members' needs. For most families, however, time pressure does not allow careful and detailed planning, so not knowing the details and feeling a loss of control generate many worries and fears.

Stage 2 is the "act of migration." A wide variety of circumstances may surround the actual journey. Zuniga (2004) describes the situation of many undocumented families: "For those who enter without documents, the horrors of exploitation, assault, and rape can be realities, replete with traumatic memories that impact their future ability to adapt and cope" (pp. 186–187). Bevin (1999) presents the case of a 9-year-old boy who witnessed his mother's rape as they were in the midst of crossing the border into the United States. For families leaving their countries of origin, there is much grief for what and who are left behind. There may be physical and emotional hardships, as well as social conflicts with other undocumented immigrants. If families can come directly to the United States, they will not experience waiting periods in holding places such as refugee camps, which can add further stressors to the accruing traumas.

Stage 3, the "period of overcompensation," involves some kind of honeymoon period after entry into the new country. For undocumented persons, the sense of newness is mixed with anxious discomfort at not knowing enough about the new country and being unable to find out more because of fear of exposure and eventual deportation. This stage quickly leads toward Stage 4, which is a "period of crisis and decompensation"—a time when the members of an undocumented family come to realize how much their illegal status prevents them from receiving help and resources. Unmet expectations, unrealized hopes, and numerous frustrations plague all family members.

Stage 5, called "transgenerational impact," is a time when immigrant families work through the integration of old and new values, allowing the younger generation to function better in society. This stage may not apply to undocumented persons, because, whether they are young or old, persons without legal papers cannot fully function in the new country. Trangenerational issues may manifest themselves primarily in terms of legal versus illegal status upon the birth of a child. When undocumented parents have a child born in the United States, the child becomes a U.S. citizen, whereas the older siblings may (like their parents) have illegal status because of the lack of proper documentation upon entry into the United States. Despite his or her legal status, the child who is a citizen still endures the tensions and fears that the undocumented family members have to endure. Sometimes feelings of resentment build up because the undocumented children cannot engage in educational or social activities because of the limitations placed upon them by their illegal status. In situations like these, the multiple traumas never cease, despite years of acculturation into the United States. Undocumented children and youth have the trauma of physically existing in an environment where they are labeled "illegal." They also have to deal with the psychological trauma of existing in a society where they are not allowed to be visible or viable participants in everyday community life.

MANIFESTATIONS OF TRAUMA IN UNDOCUMENTED CHILDREN

Cynthia Monahon (1993) defines "trauma" as follows: "Trauma occurs when a sudden, extraordinary, external event overwhelms an individual's capacity to cope and master the feelings aroused by the event" (p. 1). We use the term in Monahon's sense in this chapter, although her characterization of a traumatic event as "a sudden, extraordinary, external event [that] overwhelms an individual's capacity to cope" is somewhat broader than the American Psychiatric Association's (2000) criterion of "an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others"

(p. 467). Undocumented children do not experience a single traumatic event (in this broader sense) but multiple events, thus making it very challenging for professionals to discern and link the antecedent events that produce new or reinforce old traumas. Delgado et al. (2005) warn:

> Even if the social worker's role in working with the newcomer youth does not require or allow for any discussion of such trauma, it is critical to be aware of the degree of likelihood of traumas having occurred. Further, if the youth themselves arrived at such a young age that they have no memory of the trauma, it is important to recognize that they may be parented by those who do, and indeed the trauma may be an integral part of the "family story." (p. 49)

Young children are very aware of their parents' anxieties, and this awareness in itself can lead to feelings of being unsafe (Timberlake & Cutler, 2001; Webb, 1999).

Undocumented children experiencing trauma can have different reactions. Their signs of trauma may include panic attacks, separation anxiety, other fears and anxieties, physiological reactions, denial, behavioral regressions, and loss of pleasure. Some children may withdraw from or restrict their peer interactions. Others may have sleep-related difficulties. It is not uncommon for undocumented children to experience frightening dreams and nightmares related to their intense fears of being exposed and deported. Complaints of headaches and other aches and pains may represent the somatization of unspoken mental health disturbances (Carlson, 1997; deVries, 1996) . Personality changes may also occur, as once happy and outgoing children become sullen and withdrawn youngsters struggling to cope with the major stressors they are facing (Canino & Spurlock, 1994; Lynch & Hanson, 1998). The need to talk about and retell their traumas may initially consume undocumented children till they feel they have regained some control over their lives and situations (Suarez-Orozco & Suarez-Orozco, 2001).

CRISIS REENACTMENT PLAY THERAPY

Talking about trauma is not always comfortable or safe for children, especially undocumented children. Thus alternative modes of communication should be offered, so that the children's fears and other negative emotions can be properly expressed and processed for better functioning and improved mental health. Play therapy is one of those alternative modes of communication. It is a means for children to express their feelings through the familiar and safe medium of play, in the presence of an adult who is trained to understand and help them. Because children in general are not always able to express themselves verbally, and because foreign-born children may also be confronting language barriers, they may use toys, art materials, or other aids to work through emotions and reenact the trauma.

Several aspects of trauma reenactment through play are important. Monahon (1993) states:

> The need to retell can appear insatiable, [and] the story may need numerous retellings for the child to experience some control over it. The retelling is generally factually accurate regarding the central events and salient details, although over time, some aspects of the child's memory may become embellished with wishful fantasy—perhaps new details to the central story that wishfully recount the child's heroism or efforts to foil the danger. Some children describe the duration of time involved in the trauma as much longer or shorter than it was in reality. These distortions appear to be related to the intensity of the experience. (pp. 34–35)

Children who are experiencing a crisis due to trauma need the opportunity to re-enact that trauma in a way to comfortably resolve some conflicts. When an undocumented child has experienced multiple traumas, a skilled professional needs patience and culturally competent knowledge to sort through the premigration, migration, and postmigration contexts that may have contributed to the traumatic experiences. Because undocumented children have no legal status, they have the particular burden of being forced to be invisible. They experience discrimination in not being able to obtain services or have access to educational, financial, or social opportunities that their peers might have, because of their illegal status. Many, like Ximena in the case example that follows, need to figure out an identity that will allow them self-expression despite their undocumented status.

THE CASE: XIMENA, AGE 12

Family Information

Ximena was the youngest child of the Martinez family from Colombia.

Pedro: Age 46; Undocumented from Colombia, where he was employed as an engineer; currently employed doing maintenance at a church
Sofia: Age 41; Undocumented from Colombia; currently volunteering in a church pantry and providing part-time child care
Javier: Age 19; a senior in a public high school; retained 1 year because of poor English
Cecilia: Age 18; a senior in a private Catholic high school; a very good student; wanted to attend college
Ximena: Age 12; attending a private Catholic high school on scholarship; an average student; very social; wants to be a singer or model

The family had resided in the United States for 5 years. They held dual citizenship because Sofia's father was Italian. They came to this country on tourist visas, using their Italian passports; these had now expired. Neither parent spoke English well. Their Catholic faith was an important part of their lives.

The family was close-knit and placed a strong emphasis on education. According to Cecilia, the eldest daughter, the parents told the children that education was very important and that it was something that could never be taken from them: “My father says governments can change, the world can change, and you can lose your home, your belongings, and your money, but you can never lose your education.” The family’s stated reason for leaving Colombia was to be able to offer their children a better opportunity for education; it was unclear why the family chose the United States (where their immigration status was undocumented) rather than Italy (where they could have resided legally). In Cali, the city in Colombia where the family resided, the major industries were services for international trade and energy production. The city was also experiencing significant increases in crime and drug-related activity stemming from the cocaine cartels that dominate the countryside along the Andes Mountains. Pedro occasionally mentioned that he felt Colombia was increasingly unsafe for his family, especially the children.

Cecilia, the elder daughter, was a very bright, articulate, and outspoken girl. She often claimed that the family had sacrificed “everything for me,” because, according to her, she was the one who wanted to go to the United States to attend school. It was not clear that this was entirely true, but Cecilia expressed the belief that it was her role to carry the responsibility for meeting the family’s expectations that the children would get a good education. Cecilia was an excellent student; her grades were very high, and she did remarkably well on the SATs despite the fact that English was her second language. She had been working diligently with the school guidance counselor to research colleges and potential financial aid. She was also in counseling about college with a social worker from a faith-based organization affiliated with the church where her father was employed. However, Cecilia was growing increasingly frustrated with the realization that her immigration status was significantly impeding her college plans. At one time she was hoping to attend a private school in Pennsylvania, until she found out that she would be ineligible for any government financial aid. Her parents could not afford to pay for her college education, and she was beginning to come to terms with the fact that she would have to go to a local public university, live at home, and work part-time to support her and her family’s dreams. Moreover, it was unclear what kind of work Cecilia would be able to do; she did not have a Social Security number and because of her immigration status was technically unable to work. Cecilia was applying for scholarships that did not take immigration status into account. She had just received one from a Catholic organization, for $2,500 for each year she was in school. Cecilia stated that she wanted to become either a lawyer or a veterinarian.

Javier, the eldest child and only son, presented as a withdrawn and quiet adolescent. He had his own room in the family’s modest apartment (the girls shared a bedroom, and the parents slept in the living room), and according to his sisters, he spent a lot of time playing video games. Javier spoke significantly less English than either of his sisters. He said that in the bilingual education program at his school, there was no incentive to learn English, and most of his high school friends were Spanish-speaking Dominicans and Puerto Ricans. Javier also expressed the family's dreams of education, but clearly with less conviction than Cecilia. He stated that he wanted to attend college, but that his grades and language ability would be significant barriers. He had applied to and been accepted by a public community college. He did not express clear career goals; nor was he really able to articulate why he wanted to attend college, other than that his parents expected him to. Javier, more openly than any other member of the family, expressed that he missed Colombia and his friends in Cali. He was able to hang out with his friends in town and recalled these activities with frustration; he did not have those types of friendships here, he said.

Ximena, the younger daughter, attended the same Catholic private school as her sister. She presented as the most carefree of the siblings and seemed to enjoy herself hanging out with and socializing with her peers, both in school and at church-related activities. Although Ximena looked up to her older sister as a role model, her own grades were not especially high, and academic work was clearly less important to her. Ximena had few memories of the family's life in Colombia, other than visiting the grandparents on Sundays and enjoying the good food there. Ximena often stated that she would like to be a singer or a model.

Initial Family Contact and Presenting Problem

Soon after arrival in the United States, the Martinez family had made contact with a Catholic church; with help from one of the religious sisters affiliated with the parish, Pedro and Sofia had been able to obtain assistance to help the family settle down. Pedro secured employment with the church doing maintenance work, and Sofia volunteered in the food pantry. Through contacts with other church members, Sofia was also able to obtain part-time employment doing child care during the day. In addition, it was through the church that the girls were able to attend a private Catholic school; the religious sisters operated a social services agency for new immigrant families, and the family was referred to a counselor with this agency for help with getting their children the education for which they had made such enormous sacrifices.

Tazi (2004) notes the extraordinary emphasis placed on education by many Colombian immigrant families, as well as their parenting expectations of *el niño bien educado* (the well-educated child). According to Tazi, clinicians can use this expectation as an ally in intervening with the family. In this case, the counselor's initial sole reason for working with the children was to help them with their educational endeavors. The counselor, who had recently earned a master's degree in social work, was able to establish her credibility with the family by using her own history as an immigrant and her experience with the American educational system. As Tazi notes, the parents needed this reassurance that the counselor would understand their situation and was adequately prepared to help them. The family seemed comfortable with the counselor's taking on the role of "advisor" in guiding their children, especially Cecilia, through the college application process. The counselor met with the children every other week, either in a larger group or as a family unit, for 9 months; the counselor also met with the parents to discuss the children and other family issues for three sessions initially, and then on a "check-in" basis when there was a crisis or a problem.

The current crisis in the family revolved around the issue of Cecilia and the college that she would attend. It was clear to all family members now that they did not have the means to pay for a private college or even an out-of-town public college, because regardless of how good Cecilia's grades were, the fact of her immigration status precluded most financial aid. This was a significant blow to the family's dreams. As noted earlier, Cecilia was increasingly frustrated with the realization that her choices were limited; in addition, she was now beginning to voice anger that she would have to continue to live at home. She confided that she had recently thought that she could live in a college dormitory, and had developed significant fantasies about going away to school and coming home for the holidays to visit with the family. No doubt Cecilia had acquired some of these ideas of what college means in America from her high school peers, most of whom were native-born. Her parents, when they realized that she and the school guidance counselor were looking at schools in other states, were not happy with her dreams of going away to school. They were now expressing the desire that Cecilia and Javier go to school together, so that Javier could escort Cecilia to classes on the subway and then home. Clearly, Pedro and Sofia had little idea of what the American college experience was like and did not understand the expected social-emotional developmental aspects—the "coming-of-age" transition to independence and adulthood. They were highly focused on education as a means of acquiring knowledge, skills, and a degree.

Although this crisis most directly affected Cecilia, it was also clear that the issues raised by the family's immigration status and precarious situation also affected the other children. Ximena, 12 years old, who initially presented as the most carefree and happy-go-lucky member of the family, was seen by the counselor for three sessions. The current crisis appeared to be affecting Ximena's academic progress and her sense of identity, making her increasingly confused and anxious about herself and her family's future.

Targeted Problem of Ximena

Ximena was cheerful and playful in the first encounters when the children were seen in a group; she was clearly the comedienne of the family, although polite and respectful toward adults. By all appearances, her intelligence, social development, and cognitive abilities were well within normal bounds. Ximena was short and slightly overweight; she wore her thick, curly brown hair in a ponytail and usually arrived for sessions in her school uniform, a white shirt with a slate blue jumper skirt and navy knee socks.

The family had migrated to the United States when Ximena was 8½ years old, and she had few memories of her birthplace or of family and friends in Colombia. As noted earlier, her most significant recollections were of Sunday dinners at their grandparents' house; Ximena loved to describe in great detail the food they had there, and stated that this was one thing that she missed. She said that now Sundays were always busy, because the family would go to church, and then afterward both of her parents often worked in the afternoons and there was no one to cook a big family meal. When asked what her favorite food was, Ximena replied, "McDonald's."

It was clear from early discussions that Ximena looked up to her older sister as a role model and wanted to emulate her in every way; she even stated that she wanted to wear glasses because Cecilia wore them, despite the fact that Ximena had normal vision. However, while Cecilia excelled at school, Ximena exhibited only modest academic abilities, despite being the most fluent in English in her family. Initially this seemed to cause her little concern, and she would brush off her average grades and said that she would "just try harder, like Cecilia." In later sessions, as the crisis in the family with regard to Cecilia's being able to attend college deepened, Ximena spoke up more frequently about her own dreams of becoming a singer or a model—goals that were strikingly different from her sister's wish to become either a veterinarian or a lawyer.

According to Erikson (1963), children ages 7–12 grapple with resolving the internal crisis of industry versus inferiority; at ages of 12–17, the primary developmental task is identity versus identity confusion. In Ximena's case, these normative developmental processes were affected by the physical dislocation caused by migration, as well as the burden of negotiating bicultural adjustments and changing parental roles as the family adjusted to living in a new environment. Fong (2004) notes the importance of incorporating ecological, strengths-oriented, and empowerment perspectives into a holistic approach to clinical work with immigrants, to mitigate the risk of pathologizing the unique problems faced by this population. Such an approach promotes transactions that foster growth and development, and that assist immigrant clients in negotiating their acculturation process.

Play Therapy Sessions

As noted earlier, the counselor had been meeting with the Martinez children, Javier, Cecilia, and Ximena, for several months (both in a group as a family unit) in a social service agency. As the crisis with Cecilia deepened, it was decided to see the other children separately to assess how they were coping. The counselor had three sessions individually with Ximena, in order to assess how Cecilia's difficulties were affecting her and to formulate a plan for addressing her needs.

The first individual session took place soon after Cecilia found out she would not be able to attend the college of her dreams because of her immigration status. The second and third took place within a month and revealed the depth of Ximena's growing confusion about herself and her sense of loss and abandonment, as the family continued to focus almost exclusively on her sister's needs. The goal of the intervention was to help Ximena articulate her need for attention in the family, recognize her self-worth, and help her develop coping skills to address her own anxieties about the family's future in the United States.

First Individual Session

Content of Session	*Rationale/Analysis*
Counselor: Hi, Ximena, how are you doing? I am glad you came to see me.	Emphasis on Ximena as an individual.
Ximena: Hi. C: I know I usually see you together with your brother and sister, but I thought it would be a good idea for us to meet, so we can talk about you for a change and I can find out what's going on with you. Is that OK with you?	She is unusually quiet. In previous sessions with her brother and sister, she was the bubbly one, although lately that has not been true. So this quiet behavior reinforces that something is going on for her.
X: (*Nods, smiles.*) C: So tell me how school is going. How are your classes? X: OK. C: Just OK? I remember when you got your last report card, your mother was a little concerned that you got a C in one of your classes—math, I think it was—and you promised her that you would try harder. How is it going?	The initial purpose of engagement with the family was to help the children with issues pertaining to their education—so it is important to maintain this focus.
X: Hmmm. Well, not so good. I'm just not that good at math, I guess, like my sister. C: Well, we all have something we are good at; what's your favorite class? X: I don't know. I like music, but we only have that once a week. And I like to draw.	She is comparing herself to her sister—and she is clearly beginning to realize that she is different from Cecilia. The comparison is unfavorable and makes her seem less competent than her sister.
C: Really? I like to draw, too. I have an idea: Let's each draw a picture of ourselves—would that be fun?	Reinforcing her individuality; gently pushing her to identify what she is good at; using this as a way to move into drawing a picture of herself to see how she represents herself symbolically.
X: OK. (*Draws a portrait of herself as a short girl with a very large head, a long ponytail down to her knees, long arms, and short legs. The face is not smiling, and glasses are drawn on the face.*) C: That's a great picture—you do draw well!	What does the picture represent? The large head—full of worry? The long ponytail (her hair is soft and curly, and her parents, especially her mother, often stroke her head)—a source of comfort? The short arms and legs—being stuck, vulnerable? And the glasses—the desire to be like her sister?

X: Thank you. (*Big smile for the first time*)	
C: I have a question for you: Do you ever wear glasses?	
X: No, but my sister does.	
C: Do you want to be like your sister?	She wants recognition.
X: Yeah. She's the really smart one in our family.	She not only identifies with her sister, but has internalized the family story whereby the parents have sacrificed all for the educational opportunities of the children, and the sister is the one who is carrying the family's hopes and dreams.
C: Do you think you are smart, too?	
X: Not as smart as her.	She again compares herself unfavorably to her sister. Does she feel she is failing the family?
C: What do you think you are good at?	
X: I don't know.	

Preliminary Assessment and Treatment Plan (Long-Term and Short-Term)

Although Cecilia was the first of the three Martinez children to experience the frustrations of the limitations placed upon the educational opportunities allowed to undocumented children and youth because of their illegal immigrant status, the confused identity of Ximena was a grave concern, because undocumented children struggle with who they are. Their "secret lives"—their lack of legal status and recognition—force them to become unknowns. Ximena was of an age where she was trying to figure out who she was, and looking to emulate her smart older sister, Cecilia. The counselor felt that Ximena needed treatment to help her sort through some identity issues and the impact her undocumented status had and would later have on her.

The short-term goal was to help Ximena understand the implications of her undocumented status and to process the impact of the stress it was placing on Cecilia and the family as a whole. The long-term goal was to help Ximena find an identity that would truly reflect her own strengths and abilities. She also needed guidance in articulating her need for attention in the family, recognizing her self-worth, and developing coping skills to address her own anxieties about the family's future in the United States.

Second Individual Session

Content of Session	*Rationale/Analysis*
COUNSELOR: Hi, Ximena, how are you?	

XIMENA: (*Looks down.*) Fine, thank you.	She is still exhibiting the uncharacteristic shyness.
C: How has your week been since I last saw you with your sister and brother?	
X: OK.	
C: Just OK?	
X: Yeah.	
C: Really? When we all last met, your sister was talking about how much she was upset with not being able to attend the college that she wanted, and we talked a lot about your family's immigration status and how this was affecting the family. You didn't say much, and I want to find out from you what your feelings are. I know your sister spoke about being angry and upset. How about you?	Pushing Ximena to talk about herself and her feelings—she is holding so much inside. Direct question—talk about yourself!
X: Ummm, I don't know. My sister cries a lot. She says it's not fair.	She redirects to the sister.
C: What's not fair?	What is Ximena's understanding of her family's crisis and how it is affecting her?
X: Well, it's not fair that she can't go to college.	
C: Well, I think the issue is which college she can go to. It's clear that her choices are limited because of your family's immigration issues. You know, Ximena, I really want to know from you if, and how, you think this will affect you too. I do care about how you feel.	Reassuring her that the concern here is about her.
X: (*After a long pause and a deep sigh*) Well, my parents always said that the whole point of us coming to the U.S. was so that we kids could go to school, because, like my father says, an education is something that no one can take from you. No one else at my school has to deal with this.	Is she letting go? Almost, not quite.
C: You mean your classmates at school don't have to deal with what?	

X: Not having choices like us. The government is not fair to us immigrants.	
C: How do you think this will affect you?	
X: I don't know. My father says that we can't talk about these things outside.	She is silenced.
C: Outside where? The family, you mean?	
X: Yeah.	
C: Are you scared?	
X: (*Long pause; looks away in the distance, speaks very quietly.*) Yeah. No one understands.	Does she feel that way about the counselor as well?

Second Part of Second Individual Session

Later in the same session, the counselor engaged in play therapy to help Ximena articulate her feelings about herself and the crisis in the family. Clearly, she was not ready to talk directly about what was happening, and was articulating the family's enforced code of silence about immigration status and its impact on the family. The counselor hoped that through the play she would be able to articulate her feelings of distress, describe the invisibility she experienced in her family, and begin to focus on developing her own sense of identity.

Content of Session	*Rationale/Analysis*
COUNSELOR: You've been watching me set up this dollhouse—want to know what I am doing?	
XIMENA: Yeah. Are we going to play house?	
C: Sort of. The last time we all met, I remember Cecilia was talking about her dream of going away to college and how she would set up her own room in the dormitory—and then all of you talked about how great it would be to have your own rooms. I know right now your family lives in a one-bedroom apartment, and there is not much room for all of you. So let's do it. You move in first.	Getting her to show where she is in the family—how important is she?
X: I get the big bedroom!	That was a quick response! She knows she has needs—moving
C: Really? Why?	

X: I want it.	into the big bedroom is easy for her. Talking about herself is not.
C: Why do you think you should get the big bedroom?	
X: Well, OK, do you want it instead?	She is so used to "giving up" herself—remaining invisible.
C: No! No! Tell me why you should get the big bedroom.	
X: (*Without answering, she is already moving furniture into the largest room in the dollhouse.*)	This is indicative of how much she wants to be recognized.
C: What would it mean to you to have the big bedroom?	
X: It would be nice.	
C: And . . . ?	
X: (*Still does not answer and continues to arrange the doll furniture.*)	
C: Can you tell me what it means to have the big bedroom?	Pushing her again, harder, to articulate who is she is in the family.
X: It means you are important.	
C: Do you feel important?	
X: (*Long pause*) No.	Breakthrough?
C: Who is important in your family?	
X: My parents.	
C: How about your sister? Is she more important than you?	
X: Yeah.	
C: What would make you feel important?	
X: If I could do something really well.	
C: Like . . . ?	
X: Well, like my sister in school. She does really well. I wish I could do something like that.	She does not seem to realize there are other ways to be important besides academics.

Third Individual Session

Content of Session	*Rationale/Analysis*
(*Before Ximena arrives, the table is set up with small dolls and a stage.*)	Ximena has said in the past that she would like to be a singer or a model. The point here is to help her focus on her own identity.
COUNSELOR: Hi, Ximena, come on over here. I have a new game for us.	
XIMENA: OK. What's that? Are we going to play dolls again?	She is much more like her old self—more bubbly and engaged.

C: Here I am (*picks up a doll dressed in professional-looking clothes)*. Here I am going to work (*the doll is made to walk across the table*), and here I am at work (*the doll is set up at a desk and a chair*). People come in to see me *(another doll sits in a chair across from me*), and we have a meeting. Now show me who you are.	
X: (*Thoughtfully picks through the doll selection and picks out a doll dressed in a showy dress*.) OK—this is me.	She is a little reluctant to start, but seems to get into this play.
C: Who are you?	
X: I am a famous singer! (*Moves the doll in a strutting manner across the table*.) And I am on stage where everyone is there to see me!	She is able to name what her dream is—apart from her family's.
C: Wow! Where is the audience?	
X: Here they are. (*Proceeds to arrange other dolls in front of the singer*.) Turn down the lights! Here comes Ximenaaaaaaaaaaa!!!!! (*laughing*).	This is the most animated and clear she has been about herself, her dreams, and what she would like to be.
C: Is your family there? Have they come to see you?	
X: Oh—yeah, here they are. (*Arranges two male and two female dolls in the very front*.) Here's my mother, my father, my brother, and my sister!	
C: So all eyes on are you. How does that feel?	
X: (*Laughing*) It's great! I am the great Ximenaaaaaaaaaaaa!!!!! No one is bigger than me—not even Britney Spears!	She is the center of attention.
C: Feels great to have that kind of attention, doesn't it?	
X: Yeah.	
C: What makes it great?	
X: Everyone—my family and my friends would be proud of me.	
C: Would you be proud of yourself?	
X: Yeah—and I would be rich and I could do anything I want! The government could not stop me!	And she feels powerful.

CONCLUDING COMMENTS

Ximena and her family had privileges and status while living in Colombia, but in moving to the United States, they became undocumented and illegal persons. This status forced the family members to endure many pressures and stresses, both individually and collectively. The situation of the older daughter, Cecilia, was the frustrating reality that she would not be allowed to achieve all of her educational ambitions, despite her abilities. The family's self-sacrifices and dreams for improved educational achievements and opportunities for the children would not be fully realized. The family was going into a crisis mode as this reality sank in.

Ximena, the youngest child, did not have a sense of self and was very constricted in exploring and developing her abilities, because her undocumented status forced her into hiding and becoming invisible. Her needs were not being met, and she was at risk of developing problematic mental health issues because of the stressors Cecilia was experiencing. Her parents had limited resources, since they could not pursue jobs commensurate with their skills and abilities because of their illegal status.

Although this case is not the stereotypical case of the undocumented person coming over the border smuggling drugs and being thrown into jail, it represents a more complex problem—the invisibility with which undocumented families struggle. The family with undocumented status will have to confront a variety of disturbing situations. The struggles and stressors common to these families will require more attention and resources from helping professionals in the years to come, because of the growing ethnic populations facing these problems in the United States.

Study Questions

1. How much knowledge about a child's culture does a therapist need to have?
2. How much knowledge and understanding does a therapist need of the historical and political events that have shaped the trauma a child has experienced?
3. How important would it be for the parents to be informed about the identity issues with which Ximena was struggling?
4. At the end of the second session, the therapist was wondering whether Ximena was feeling that the therapist did not understand her. How might the therapist have checked to see if this might be true?

Role-Play Exercises

1. Create a role-play situation where the therapist is listening to Ximena explain what her family's situation of being undocumented is like, and how that frustrates Ximena because she can't have friends come to her house to do homework or hang out.
2. Create a role-play situation where Ximena is explaining to her parents that she wants to be a singer or a model, and not always to be like her older sister, Cecilia.

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Chapter 20

Brief Narrative Play Therapy with Refugees

Ann Cattanach

> All's done,
> All's said
> Tonight
> In a strange bed
> Alone
> I lie
> So slight
> So hid
> As in a chrysalid
> A butterfly
> —An English nursery rhyme

This chapter describes brief interventions with refugee families and children, who have specific difficulties that need to be understood in the context of their life experiences. In these interventions, both individual children and families explore narratives together with the therapist—a process that can help them integrate their present issues into a coherent form emphasizing the safe elements of their present circumstances.

TERMINOLOGY: REFUGEES, REFUGEE STATUS, ASYLUM SEEKERS, AND UNACCOMPANIED CHILDREN

In this chapter, I use the term "refugees" to refer both to persons who have achieved formal "refugee status" (i.e., who have been recognized by the governments of their host countries as refugees) and to persons who are seeking such status but have not yet formally attained it. The United Nations (1951), in its *Convention Relating to the Status of Refugees*, states that to be recognized as having refugee status, a person must have left his or her own country or be unable to return to it, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion." Refugee status prevents a person from being returned to his or her country of origin. It may include other rights as well, depending on the laws of the host country; for example, in the United Kingdom, it includes the right to bring immediate family members into the United Kingdom. Strictly speaking, persons who have crossed an international border in search of safety and refugee status in another country are referred to as "asylum seekers."

Both formally recognized refugees and asylum seekers may be families or individual adults—and, increasingly, may be individual children as well. In the United Kingdom, the term "unaccompanied children" refers to children who travel from or flee their country of origin without their parents. Frequently such children *are* accompanied by a sibling, relative, benefactor, family friend, or other young person, or the agent who arranges the trip; usually, however, these travel companions are unwilling or unable to provide appropriate care in the destination country. Some unaccompanied children have parents who have been killed or arrested; for others, life is too dangerous at home (e.g., young children are faced with military conscription). A recent study of 218 separated children who had come to Western Europe listed reasons such as these:

> Violent death of parents; detention and torture of the child; armed conflicts that target child civilians; genocide; forced recruitment of children into the armed forces, some under 10 years of age; trafficking of children for the purposes of prostitution under brutal conditions; persecution of child's ethnic group; denial of education due to child's ethnic identity; political activities of child or child's family members resulting in persecution; rape and sexual assault; abuse and/or abandonment by parents; poverty and complete lack of opportunity. (Ayotte, 2000, p. 9)

In a case example later in this chapter, I describe narrative play therapy with such an unaccompanied child.

As these descriptions make clear, refugee children (with or without their families) have experienced such fear and danger in their countries of origin that they are forced to flee. The disruption of flight away from danger is a further layer of fear. Then they have to cope with living in a new country, with different rules, strange faces, often a different language, and countless other differences. In addition, achieving refugee status is a long, confusing administrative process, and persons in the throes of this process fear rejection by the host country. Racism, and other forms of prejudice and antagonism, are often encountered by refugees as well. Therefore, for them to trust professional interventions is a huge leap of faith.

RATIONALE FOR BRIEF NARRATIVE PLAY THERAPY INTERVENTIONS WITH REFUGEES

For some refugee children and families, it can be helpful to offer brief narrative play therapy interventions. Such interventions can create a safe space where a family or an individual child can achieve a sense of autonomy, or where family members can choose to be playful with each other or with the therapist. Perhaps they can recall past rituals of family life, enact present rituals, or create new ones through the safety of imaginative play. They can surrender to the moment and perhaps feel a sense of calm. It is important to follow the requirements of family members or individuals and accept their needs, not to feel that the role of the therapist is to help them narrate past horrors. The story that family members want to tell is their story in their lives as events are experienced in the here and now. The therapist can help the family to construct such a story—one that places the events in the context of culture and the circumstances of their present life.

The purpose of taking a narrative approach to play therapy is to explore the stories children present in play and to facilitate an exchange of ideas and thoughts about the stories. This approach means that the relationship between children/family members and therapists is one of co-construction—sharing ideas and listening to each other to find how best to support the children in what they want to say. This is a hermeneutic stance, because a therapist's listening response is a continuous inquiry about the material presented in a play session. This developing narrative always presents the therapist with the next question. This is a "not-knowing" position; the therapist's understanding is always developing. This is an important stance in working with refugees, because most therapists will not know the impact of the refugees' experiences, share their cultural understanding of what has happened to them, or know the rituals that were the cement of their former lives.

SOCIAL CONSTRUCTION THEORY

Therapists who use narratives in a collaborative approach with children and families need to understand social construction theory, which describes narratives as the ways we humans construct our identity. Proponents of this theory (e.g., Burr, 1995) state that all ways of understanding are historically and culturally relative; that is, they are specific to particular cultures and periods of history. Products of a certain culture and phase of history are dependent on particular social and economic arrangements prevailing in that culture at that time. Knowledge is sustained by social processes, and shared versions of knowledge are constructed in the course of our daily lives together. We make use of words in conversations to perform actions in a moral universe. What we define as truth is a product not of objective observation of the world, but of the social processes and interactions in which we are constantly engaged with each other.

When therapists meet refugees, they need to negotiate the space between their own and the refugees' cultures and expectations, and to recognize that each view of the world is specific to each set of cultural experiences. So a child/family and a therapist need to construct a space and a relationship together where the child/family can negotiate a personal and social identity by finding stories to tell about the self and the lived world of that self. The partnership agreement between child/family and therapist gives meaning to the play as it happens. The stories children tell in therapy are imaginative expressions of what it feels like to live in their real and imagined worlds. The worlds of the stories can be mediated by the therapist, who can help to sort out cognitive confusions present in the play. Sometimes there is a process of "re-storying," in which a child can try out new aspects of self by taking on a role and exploring a world from the perspective of that role. A major aspect of this kind of play is the constant affirmation between child and therapist that the play is "only a story" and does not necessarily have to be lived in the world of reality.

NARRATIVE THERAPY

These processes of storying and re-storying experiences are what narrative therapy explores. Le Vay (2002) has described the expression of narrative identity as one of the fundamental processes in play therapy, because this process enables the child and therapist to explore relationships via the symbolic and metaphoric imagery that is co-created during the course of the play. Humans have a natural inclination to story personal experience, and the richness of symbolism and metaphor in this process becomes embedded in the relationship between child and therapist. Thus narrative frameworks are constructed that allow a child to begin to sequence, order, predict, and make sense of complex feelings that can exist as a result of abuse or other trauma. Le Vay (1998) believes that we humans realize ourselves through the stories that we tell both others and ourselves. The words we say, the sentences we construct, and the events that we choose to include or omit all contribute to the generation of narrative identity, through which we aim to make sense and order out of experience.

Lax (1992) has stated that human interaction itself is where the text exists and where the new narrative of one's life emerges. This unfolding text occurs between people, and in therapy clients unfold their stories in conjunction with a specific therapist. The therapist is always co-author of a client's unfolding story, in partnership with the client. The resulting text is neither the client's nor the therapist's story, but a co-construction of the two. Lax (1999) defines a narrative therapist as someone who assists persons to resolve problems by enabling them to deconstruct the meaning of the reality of their lives and relationships, and to discern the difference between the reality and the internalized stories of self. The narrative therapist encourages clients to re-author their own lives according to alternative and preferred stories of self-identity.

Narrative therapy has links with those therapies that have a common respect for the client and an acknowledgment of the importance of context, interaction, bonding, and the social construction of meaning. In narrative therapy, therapist and client can explore roles, identity, and life events in order to make sense of experience. The resulting narratives can be about lived life or imaginary worlds.

NARRATIVES AND STORIES

It is through narratives and stories that the child and therapist locate common themes important to the child in ordering their experiences. In narrative play therapy, both formal storytelling and more informal narratives are explored. The difference between a "narrative" and a "story" in this context is that a narrative is embedded in a conversation or communication between people and is not necessarily experienced as a story by the listener or speaker, while a story is communicated intentionally. A narrative is sequenced in time and conveys a meaning. It can be either an imagined event or an everyday event that is described, but the communication between narrator and audience is not formalized as it is in storytelling. Bruner (1996) has called a narrative a construal of reality, and he considers narratives as essential to life in a culture.

SEVEN CONSTRUCTS FOR THE USE OF NARRATIVES AND STORIES IN PLAY THERAPY

1. Telling stories and playing stories can be ways of controlling our world and what happens to us in that world. For a child who lacks power, they can be enriching experiences. For once the child can say, "I'm the king of the castle," and not experience the consequences of his or her world of reality.
2. The use of narratives and stories in play therapy can help children not only make sense of their own lives, but also learn empathy through imagining how other characters in their stories might feel.
3. Working with stories and narrative play means that there is collaboration between child and therapist; what happens in the sessions is co-constructed between the two.
4. As described above, this model is based on social construction theory and narrative therapy, which view the development of human identity as based on the stories we tell about ourselves and the stories others in our environment tell about us.
5. Some dominant stories people have about themselves are not helpful and can lead to victimization. In play and drama therapy, therapists and clients can explore ways to shift and expand aspects of identity through exploring roles and ways of being in play, knowing that clients do not have to take all these experiments into their lived lives.
6. This approach also recognizes the fact that the developing child is part of an ecological system, not an isolated individual. We all live in a particular time and culture, and this influences our way of seeing.
7. In this kind of collaboration, children can play with small toys and objects, create a dramatic event, draw a picture, or just make marks on clay. But as they do so, they tell stories about what they are doing. My role as therapist is to listen, perhaps ask questions about a story if required, and record the story by writing it down if a child requests it. If the play becomes a drama, then I may take a role if the child wishes. I may also share a story that may be congruent with the play of the child, or may serve as a way to deepen the relationship by the shared experience of telling and listening.

THE REFUGEE CHILD/FAMILY AS PART OF THE ECOLOGICAL SYSTEM

Bateson (1972) described persons and the symbolic world of culture as existing within a system of interdependent relations. As emphasized throughout this chapter, we humans live within a specific culture at a particular moment of time and develop our identity through our interactions within that culture. Bateson defined the unit of survival as a flexible organism-in-its-environment. He viewed the individual as part of a larger aggregate of interactional elements. These interactions involve information exchanges, and it is the totality of these exchanges that make up the mental process of the system, of which the individual is only a part.

Imagine the members of a refugee family who have changed their cultural world and are trying to understand the rules of a new culture. They inhabit this new culture out of necessity, not often through personal or family choice. They need information exchanges to understand how to function in this new place and space.

Bronfenbrenner (1979) defined the "ecology of human development" as progressive mutual accommodation between the growing human being and the changing properties of the immediate settings in which the developing person lives. This development is affected by relations between these settings and by the larger contexts in which the settings are embedded. Bronfenbrenner defined subsystems of several sizes within the overall ecological system: the microsystem (small), the mesosystem (medium), the exosystem (large), and the macrosystem (very large).

The "microsystem" is the child's life in the family or school, with the daily routines, roles, and interpersonal relations experienced by the developing person within the immediate setting of home or school. The "mesosystem" consists of the interrelations among two or more microsystems in which the developing child actively participates—for example, the relations among home, school, and the local peer group. The "exosystem" refers to one or more systems that do not involve the developing person as an active participant; however, events that occur in the exosystem influence what happens in the setting containing him or her. The "macrosystem" consists of the culture and the society into which the individual is born, including such cultural beliefs as what it is like to be a child and how children should be reared.

According to Bronfenbrenner (1979), human development is a process through which the developing person acquires a more extended, differentiated, and valid conception of the ecological environment. As a result, the person becomes motivated and able to engage in activities that reveal the properties of, sustain, or restructure that environment at levels of similar or greater complexity in form and content.

Bronfenbrenner's constructs assume a continuity of culture, however, which is not the experience of the refugee child and family. The culture of their birth country has been left behind. The family may be strong and supportive, but there will be new routines of daily life to be absorbed in unfamiliar surroundings. An unaccompanied child will not have the support of family and can be easily lost (in many senses of the word) in an alien place. The relations with the school and peer group may also be fraught with difficulties: There may be a new language to learn, difficulties understanding school rules, and/or a lack of friends who understand. And the wider society can be hostile or rejecting toward refugees, with many rules and conditions to fulfill before they can achieve formal refugee status, as well as the fear that the rules will change and they will be sent back to their home country to face prison or death. Sometimes families seeking asylum are moved from country to country, never knowing where they might find acceptance. And always there is the conflict between the culture of their homeland and the culture of the host country.

CONSTRUCTING THE INTERVENTION: PLAY THERAPY AS A CULTURAL ROUTINE

The way the therapist negotiates the beginning of a play therapy intervention with a refugee child is crucial to the co-working of the interaction. If the structure is clear, the meeting becomes another cultural routine, which gives the child a sense of belonging—a place where the child has a role and responsibilities.

Corsaro (1997) describes a "cultural routine" as a place where the child has the security and shared understanding of belonging to a social group. Because the routine is predictable, this provides a framework within which a wide range of sociocultural knowledge can be produced, displayed, and interpreted. These routines serve as anchors, which enable the child to deal with ambiguities, the unexpected, and the problematic while remaining within the confines of everyday life. Participation in cultural routines begins early with, for example, simple participation in the game of peek-a-boo. This game is found in some form in most cultures. The child first learns a set of predictable rules that make up the game; then the child learns that embellishment of the rules is possible as the play routine develops. Initially in such routines, the games often proceed on an "as if" assumption. This means that the adult assumes that the child is capable of social interaction until the child gradually learns to be socially competent and can fully participate in these social routines.

If play therapy is explored as a cultural routine, then the structure of the play must be well described to the child. The rules and boundaries are vital to the safety of the relationship and clarify the roles and responsibility for both therapist and child. The child needs to feel safe with the therapist, but must also feel confident that the therapist can enter his or her play world and help make sense of the confusion and misunderstandings that may be creating difficulties for the child. In this way the therapist does not interpret play from some esoteric source of knowledge, but together with the child mediates some satisfactory meaning, which is congruent with the child's social world.

As the routines are learned and experienced, then the child expands the meanings of the play and stories, and learns more complex social communication. The mediating materials are the play, story making with toys and objects, and stories the therapist tells or reads to extend the child's individual experience to a cultural generality. It is important in working with refugee children and families to check which toys are acceptable and to find toys that are familiar to specific cultural groups.

CASE EXAMPLE: LINKING THE PAST TO THE PRESENT

The first case example illustrates playing to establish safe rules and boundaries with a refugee child who was struggling to feel part of his adopted family and community. Tom was an 8-year-old refugee from Romania who had been adopted in the United Kingdom. He enjoyed the routines of play and liked the rules about the use of toys and other materials. He used our time together as a breathing space where any demands came from him and he could make his own world with his own rules, rather than try to understand what he was meant to do in this new country with this new family.

Tom couldn't talk about his world directly, but he was able to explain how he felt through his imaginary stories. He enjoyed telling stories with small figures, but didn't like to create narrations about his present life. He told the following story by using small toys in a sandtray, and the story was written down for him.

The Beach Scene

Now the dogs are back on the beach.
They meet the other dogs.
The mermaid was hidden away.
Her hair was hidden until she was buried.
Then the RSPCA [Royal Society for the Prevention of Cruelty to Animals] man came and checked up on all the dogs.
He also brought the operating table.
He must check up on all the dogs.
But one day a bad thing happened.
As the man was inspecting the dogs, a big dump of sand came and buried him.
He was buried.
Nobody could save him.
Another man came and took the dogs back to the centre.
Now all the family are back at home.
Granddad came to stay with Grandma.
They want to see the children.
Grandma is playing games with the children.
One evening there is a big storm.
Grandfather is really scared.
All the babies are really scared.
They have lots and lots and lots of kids.

A big family.
They are English, Indian, Jamaican.
No Romanian children.
They don't want them.
Now it is nighttime.
All the children are in bed.
They have to have a big, big bed to sleep in.
There are so many children.
And the mum [mother].
They all have their little toys.
Then they fell fast asleep.

This story was multilayered, with memories of birth family members, the orphanage, images of not being a person, and the routines of life all embedded in it. It was only through such play and stories that Tom could explore memories of the orphanage—of children being sorted like dogs—and could also state his feelings that being Romanian was somehow shameful. "Nobody wants Romanians," he said. Each child in the orphanage had a little toy, and the "mum" was the caregiver who looked after the whole group at night. This story was told at a time when there were very negative stories about Romanians in the press, which reinforced Tom's view of himself as a nobody.

Tom had great anxiety about making attachments in his new family, and his time in the orphanage had left him with developmental delays. As noted above, Tom enjoyed our sessions because the rules and structure to keep us safe so he could play were clear, and there were no other demands on him. After our sessions together, he and his adoptive family were able to get further help for the attachment issues, as well as educational support and assessment.

CASE EXAMPLE: HELPING A FAMILY DEAL WITH TRAUMA IN THE HOST COUNTRY

The second case example illustrates the use of play to help a family make sense of a trauma experienced in the here and now in the host country. Sue, age 8, was a Somali refugee who lived with her mother, sister, and two male cousins. They had witnessed the horror of war in Somalia, and one of the male cousins, age 15, had been a boy soldier. He was traumatized by the events he had witnessed in Somalia, and one night he experienced a psychotic episode. During this episode, he entered Sue's bedroom and attempted to sexually abuse her. Her sister called out for help, and her mother came and stopped the abuse.

The cousins subsequently went to live elsewhere and to receive the help and support they needed, so Sue was kept safe. However, Sue was very frightened by the event and was still unable to communicate with her mother about the incident some 3 weeks after the event. In discussion with her mother, through an interpreter, I described a play therapy session, and the mother and Sue decided that it might help both of them to use play to show what had happened.

Sue, her mother, the interpreter, and I met together. We all sat on the floor together, and we talked about playing this scary event. I had a selection of play figures, including human figures, wild and domestic animals, and magical creatures like dragons. Nurtured by her mother and encouraged by the interpreter, Sue began to choose some play figures to tell her story. She selected a small female figure to represent herself, and a gorilla on all fours to represent her cousin. With the help of these figures, she then enacted the event. It was clear that the image of the gorilla expressed very clearly what it felt like to be woken by this seeming monster on her bed.

Sue enacted the story three times to get the details clear for herself. We all reinforced how brave she had been, how she had been kept safe by the family, and how her safety was assured by the actions of her mother. Sue was encouraged to continue to talk to her mother about the event, and the meeting ended with the mother hugging Sue and quietly comforting her.

Sue needed to tell her story in her own way, using a gorilla to represent her cousin during the attack. Her mother was also able to tolerate the narration as told by Sue, and this sharing continued after the play. Sue's mother also felt empowered, because it was recognized that she had protected her daughters by effecting the removal of the cousins—which would also be helpful for the cousins, as they would receive treatment and support. The elder daughter was later praised as well for her part in protecting her sister by calling for help.

The role of the interpreter was very important in this intervention. She had received training in interpreting in child and family mental health environments and was a trusted member of the Somali community. She was able to reassure the family before the meeting. She was supportive during the play but not intrusive, translating everything, as was the agreement before we began the play.

THE ROLE OF INTERPRETERS

As the case of the Somali family illustrates, many interventions in play therapy with refugees will include an interpreter as part of the multidisciplinary team, and it is often only through this person's communication skills that an intervention is possible. Whenever possible, such an interpreter should hold formal interpretative qualifications, should be bound by a code of ethics, and should have work experience in child and family mental health.

An interpreter can be a rich source of information about the culture of refugee children and families, especially about the cultural aspects of children's play. The therapist will need time with the interpreter before and after the intervention to discuss and debrief. The therapist will also have a duty of care to the interpreter, and if a child is talking about traumatic events, it is important to debrief and support the interpreter. Qualified interpreters may also have their own ongoing support or supervision.

Raval (2000) describes a collaborative approach to working with interpreters and families in the context of child and adolescent mental health services in the United Kingdom. Tribe (2005) provides a helpful list of do's and don'ts in her article, "The Mental Health Needs of Refugees and Asylum Seekers." Raval and Tribe (2002) are also coeditors of the book *Working with Interpreters in Mental Health,* which sets out the role of the interpreter and explores a range of issues for interpreters and professionals working together in mental health settings.

CASE EXAMPLE: PLAY WITH AN UNACCOMPANIED CHILD REFUGEE

Pat, who appeared to be about 11 years old, came to the United Kingdom from Africa, brought by two men who said they were his uncles. However, once Pat was admitted into the United Kingdom, they refused to take responsibility for him. It appeared that they were not his uncles, but workers in the consulate of their African country, and had brought Pat into the United Kingdom because his family members had all been killed in the war back home.

Pat was taken into foster care, was placed with an African family, and seemed to be settling down well. He worked hard at school, and he was fluent in English, which he had learned at school in Africa. However, Pat was troubled by several past and present concerns; although he was fearful of talking about these, he said he would like to meet with me for some play therapy. Initially, Pat was anxious because he was afraid that if he said anything he would be sent back to Africa. He was reassured that, legally, he was a "looked-after" child and the responsibility of the U.K. community in which he now lived. We made rules about what would be confidential in the sessions, and I also made it clear that he had no obligation other than to play.

Pat loved playing with small toys and figures, and made up many imaginary stories about fighting and wars. He enjoyed the structure of narratives and stories. At the end of the play, he would talk about his life in Africa. He told me that he had been forced to witness the sexual and physical assault and shooting of his mother by rebel fighters, who then released him and other family members. The other family members had subsequently also been killed by rebel soldiers, but Pat had not witnessed these deaths. He said that the way he came to the United Kingdom was a secret, which he was obliged to keep. He wanted to do well at school, because he hoped one day to go back to Africa as an educated person and contribute to his country.

Pat's major concern in the present was to protect the objects and small personal mementoes from his past life in Africa and his present life in the United Kingdom. He was afraid that the other children in the foster family might destroy his things. We decided that he needed a large box or suitcase with a strong lock so he could store his valuable objects. We found an excellent large wooden box, very strong, with a padlock and a hook for the padlock. All the special things could be stored and kept safe.

After this, Pat began to be a more relaxed member of his new family. His foster parents respected his need for privacy and placed his box in a safe place so nobody could interfere with it. He had been able to make a story of his life so far, which was tolerable for him, although terrible in content. He had a witness who had listened to his story with no intentions other than to listen. However, Pat still had many secrets and friendships that he kept to himself. He had lived in a country where to share knowledge of friends and associates could mean certain death, and he still felt fearful for family members back home. So his secrets were respected.

After eight sessions together, we parted. Pat felt safer in his foster family and was able to share more of his life as he was presently living it. He also felt that his memories of his family in Africa were safe in his box. He could open the box when he felt the need, but it was safe from the prying eyes of others. Now he could get on with his life.

CONCLUSIONS

There are many issues to be considered in play therapy with refugees. These include (but are by no means limited to) traumas from the past, cultural and language differences, fear of rejection by the host country, racial abuse, poverty, and possibly detention or imprisonment until refugee status is defined. The key for the play therapist is to respect each family and to focus on the specific issues that the child and family want to address. The danger is of becoming overwhelmed and losing perspective. So the therapist needs to listen and be a witness; offer playful moments and the comfort of play; find rituals for the family members that comfort and support them; and tell stories together.

As a final offering, I encourage you, dear readers, to think about the following Ukrainian story (*Ukrainian Folk Tales*, 1986) and consider those who live less fortunate lives.

> *Sad and Happy Songs.*
>
> Once upon a time there lived a man and his wife who had a whole houseful of children, but only enough land for a rabbit to hop over.
> They worked day and night, all of them, just to keep body and soul together. They loved songs and were always singing.
> Some time passed, and the wife died.
> This was a terrible blow to the man and his children, and only sad songs were sung in the house.
> Not far from their house lived a great lord.
> One day he came to their house with a purse full of money.
> He asked the man how many children he had.
> “Ten,” the man replied.
> “Isn’t that too many for a house like yours?” said the lord.
> “Let me take one of them and you can take the purse.”
> The man called his children.
> “The lord offered me a purse full of money in return for one of you,” he said.

"Does anyone want to go with him? The one who does will eat white buns and sleep on feather beds."
The children burst out crying.
"No one wants to go with you, sir."
The lord thought it over.
"Oh, well it's up to you, but your songs keep me awake, so I'll let you have the money if you stop singing them."
"So be it," the man agreed.
He took the money, and the lord went away.
For a time silence reigned in the house.
But one day one of the boys suddenly started singing.
And so sad was his song that the other children began to cry.
The poor man took the lord's purse and hurried to him with it.
He threw the purse on the table in front of the lord.
"I'm sorry, sir, but neither my children nor their songs are for sale."
And from that day on the poor man's house rang with songs—sad songs and happy songs.
And his children might be singing today
Had they not all died of hunger.

Study Questions

1. Discuss with your group the importance of cultural rituals for refugee families.
2. What systems do you have to make connections with interpreters?
3. Select a particular refugee group and find out how the adults play with children.

Role-Play Exercises

1. Have two players select a country of origin, and explore a play therapy intervention with an interpreter from the chosen country of origin.
2. Have three players role-play a therapist, a child, and an interpreter in a play therapy session where the child is offered a selection of small figures, animals, and other toys, and is asked to describe a bullying incident at school.

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Part V

SUPPORT FOR THERAPISTS

Chapter 21

Helping the Helpers

GUIDELINES TO PREVENT VICARIOUS TRAUMATIZATION OF PLAY THERAPISTS WORKING WITH TRAUMATIZED CHILDREN

Katherine Ryan
Maddy Cunningham

To be effective in psychotherapy with children, therapists need to enjoy children, want to help them, and yet have the capacity to listen to and endure children's pain. Bearing witness to the pain and helplessness of children who have been traumatized can take its toll on a therapist. This chapter focuses on the impact of working with traumatized children, and on ways a therapist can manage the emotional effects of this work.

Children entering psychotherapy often present with a series of symptoms indicating that their functioning in school, play, and/or relationships has been compromised. While the meaning of these symptoms is not always clear to the therapist at the beginning of treatment, some of these children will later reveal an exposure to trauma. Sometimes children enter treatment without anyone's knowledge that they have been traumatized. Symptoms of irritability, stealing, lying, worries, oppositional behavior, fears, and/or sleep disturbances can lead to diagnoses of mood disorders or oppositional defiance. Careful assessment, however, may reveal experiences that have indeed been traumatizing. The types of trauma to which children are exposed are vast and can include physical, sexual, and emotional abuse, natural disasters, community violence, terrorist events, domestic violence, media violence, and severe accidents.

In this chapter, we first provide an overview of the challenges faced by the therapist working with traumatized children. We then briefly discuss the concepts of "countertransference," "general psychological distress," "secondary traumatic stress," "compassion fatigue," and "vicarious traumatization" as frameworks for understanding the stress of working with traumatized children. Techniques for managing reactions are offered next, followed by a case example in which the concepts are applied.

Trauma occurs when a child's sense of safety has been invaded, causing such severe disturbances in his or her cognitions and feelings that the child's perception of safety is severely altered. Perry (2002) defines a traumatic event as "a psychologically distressing event that is outside the range of usual human experience. Trauma often involves a sense of intense fear, terror, and helplessness." The American Psychiatric Association (2000, p. 467) defines exposure to trauma similarly but more specifically: as experiencing, witnessing, or being confronted with "an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others," and as responding with "intense fear, helplessness, or horror." In addition, the level of the child's emotional maturity, the degree of threat, the length of exposure to and nature of the threat, the absence or presence of supportive caretakers, and the child's culture all mediate whether and to what extent a child feels traumatized. These multiple factors interact and are diagrammed in the tripartite assessment (see Webb, Chapter 1, this volume).

CHALLENGES FOR THE THERAPIST WORKING WITH TRAUMATIZED CHILDREN

The therapist faces many challenges in working with children who have been traumatized. Most importantly, the therapist provides a relationship that communicates safety and life beyond trauma. He or she also helps contain the child's affect, the child's secret (when one is present), and the child's ambivalence about revisiting the memory of the bad things that happened. In addition, the therapist often "bears witness" to the horrific event and the child's subsequent feelings. Child trauma has been described as more difficult than other child problems for therapists to deal with, because it is "provocative" (Figley, 1995, p. 16); that is, the images presented by traumatized children tend to be highly intrusive and vivid (Brady, Guy, Poelstra, & Brokaw, 1999). Therapists working with traumatized children tend to have a stronger identification with them (Dyregrov & Mitchell, 1992). They may experience the same sense of helplessness the children feel, and therefore may become overwhelmed and feel ineffectual (Nader, 1994). A child's other reactions to terror, including rage and the desire for retaliation (Coppenhall, 1995; Nader, 1994), may also be difficult for a therapist to tolerate.

Posttraumatic play can be morbid, constricted, joyless, and unaccompanied by relief, making the task of bearing witness to it very challenging. In addition, because children can often only tolerate very limited direct discussion of trauma, therapists can feel pressure to address it with few words adequately within the play.

Therapeutic work with children who have been traumatized by terrorism or other acts of human intention can be especially difficult, due to some of the damaging sequelae of such acts. These effects include aggression, trauma-related fears, loss of positive esteem for others, trust problems, pessimism, and irritability (Terr, 1991; Koplewicz et al., 2002; Silverman & La Greca, 2002; McCann & Pearlman, 1990; Janoff-Bulman, 1992; Nader & Pynoos, 1993; Garbarino, Kostelny, & Dubrow, 1991; Webb, 2004). Such a child needs to heal within the context of a healthy therapeutic relationship (Herman, 1992). However, the impaired relational ability that results from traumas such as terrorism or child abuse can create difficulties in the engagement and maintenance of the therapeutic alliance. This difficulty in developing the therapeutic relationship, combined with the child's overwhelming experience, may lead the therapist to feel a loss of confidence in his or her abilities.

Children naturally evoke protective and nurturing feelings in most therapists. These can be especially strong when children have poor living situations and are without protective and understanding adults in their lives. Recognition of a child's sense of helplessness and loss of innocence can evoke strong feelings of protection and nurturance in a therapist. Again, it is not the *presence* of these feelings in the therapist that is deleterious for the treatment; it is the *mismanagement* of these feelings that can interfere with the treatment process. While protectiveness and nurturance are important components of altruistic therapeutic behavior, being overprotective or taking an overly nurturing therapeutic stance can prevent a child from exploring all the feelings he or she needs to work through in relation to the trauma (Webb, 1989).

Another factor to be considered is that therapy with traumatized children usually includes collateral work with their parents, including the provision of support, information, guidance, and hope. Often parents are so derailed by knowing that their children have been traumatized that they need major support to assist their children. Working with parents of traumatized children can be quite intense and, at times, complex. Therapists may also experience the negative effects of inadequate, limited, or dysfunctional community resources; sometimes these may leave a therapist feeling that he or she alone must address all the client's needs. It is very likely that over time, the sense of bearing this burden without assistance will have a significant impact on the therapist.

In addition, a therapist is frequently drawn into a number of roles relative to external systems. The therapist's role can get blurred by advocacy and case management responsibilities (Friedrich, 1990). Consultation with foster parents, child care workers, and teachers may be expected. The therapist also often must testify in court and make difficult recommendations and/or decisions regarding a child's permanent placement. These varying roles can easily pull the therapist away from the empathic connection to the child and into a mode of greater or lesser action on the child's behalf. These are difficult roles to balance and manage within the therapy.

CONCEPTUAL FRAMEWORKS FOR THE STRESS OF TRAUMA THERAPY

Several concepts describe the experience of therapists working with traumatized children. These include "compassion fatigue" (Boscarino, Figley, & Adams, 2004; Figley, 1995), "secondary traumatic stress" (Figley, 1995), "vicarious traumatization" (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), "traumatic countertransference" (Herman, 1992), and "general psychological distress" (Stamm, 1997). While there has been a great deal of empirical (Boscarino et al., 2004) and anecdotal support for these concepts, several authors have recently complained that these concepts overlap and lack construct clarity (Boscarino et al., 2004; Stamm, 1997; Kadambi & Ennis, 2004).

We have chosen to include a brief overview of several concepts that capture the stress associated with working with traumatized children, as readers may find a particular concept more helpful than others. For example, some therapists may find that their reactions are better conceptualized as "general psychological distress," whereas others may find that the concept of "vicarious traumatization" describes their experience better. Our purpose is to provide therapists with frameworks for understanding and processing their reactions, rather than exhaustive definitions of the concepts and their relationship to one another. For a more detailed description of each of these concepts, the reader may consult the original sources cited. The techniques to prevent or alleviate the stress of trauma work described later in the chapter are applicable to all of the concepts.

Countertransference and General Psychological Distress

Historically, the term "countertransference" (CT) has been used to describe the experience of therapists in the therapeutic encounter. While definitions of CT vary, there is often an implication that the therapist's unresolved personal issues account for his or her reactions to clients and their difficulties (Gorkin, 1987). The nature of CT evoked by working with traumatized children appears to have a distinctive quality related to the content presented by the clients (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

It is helpful to distinguish CT from "general psychological distress," which occurs immediately following exposure to upsetting clinical material. For example, after a session in which graphic abuse is revealed, the therapist may feel aroused, disgusted, overwhelmed, or acutely sad. These feelings may be transitory and, though distressing, are not necessarily problematic. The concepts of "secondary traumatic stress" and "vicarious traumatization" are more applicable when therapists experience reactions that are more intensive and pervasive.

Secondary Traumatic Stress and Compassion Fatigue

"Secondary traumatic stress" (STS) is defined as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other . . . " (Figley, 1995, p. 7). It includes the various emotional, cognitive, and physical consequences of providing professional assistance to victims (Salston & Figley, 2003). Figley (1995, p. 9) suggests the term "compassion fatigue" is an "appropriate substitute" for STS. He notes that the phenomenon may cause the therapist to struggle to maintain an empathic connection with the client. If a therapist has nightmares, intrusive daytime thoughts, or emotions related to a specific client, or finds him or herself resisting contact with a client, the therapist may be experiencing either STS or compassion fatigue. (See the case example presented later in this chapter for an illustration of STS.)

Vicarious Traumatization

The concept of "vicarious traumatization" was developed by McCann and Pearlman (1990) to describe the impact on the therapist of ongoing exposure to images of terror, helplessness, violence, and suffering as a result of the therapist's empathic engagement with clients' trauma material (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995, p. 31). The concept of vicarious traumatization focuses on this exposure's effects on the therapist's cognitive world view. "Our notion of vicarious traumatization . . . implies that much of the therapist's cognitive world will be altered by hearing traumatic client material . . . and that all therapists working with trauma survivors will experience lasting alterations in their cognitive schemas, having significant impact on [their] feelings, relationships, and life" (McCann & Pearlman, 1990, p. 136). This disruption may be accompanied by feelings of depression, hopelessness, and inadequacy. Like their traumatized clients, therapists may begin to question their own safety or the safety of loved ones, the meaningfulness of life, and (in the case of intentionally caused trauma) the nature of humanity (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Vicarious traumatization, CT, and STS are different yet integrally related, each affecting the other. "*Countertransference* is specific to a particular therapeutic relationship [whereas] *vicarious traumatization* is manifest across trauma therapies" (Pearlman & Saakvitne, 1995, p. 317; emphasis in original). If a generalized distress response, CT, or STS intensifies and goes unattended, the therapist's overall view of the world, the self, and other personal relationships can be gradually and negatively affected, leading to vicarious traumatization. If these changes in the therapist are unconscious, they may affect the therapist both professionally and personally. Unaddressed vicarious traumatization may negatively influence not only the therapist's work with clients but his or her professional identity, sometimes leading the therapist to make career changes. Personally, the therapist may be left feeling depressed, anxious, and drained, and may withdraw from and ultimately lose personal relationships (Pearlman & Saakvitne, 1995).

Therapists may be experiencing VT when they have more pervasive symptoms, such as ongoing nightmares, and increased anxiety specifically regarding their safety. Therapists may feel vulnerable, have difficulty trusting or be flooded by strong emotions such as grief or anguish. They may defend against the pain and feel numb or even callous (Pearlman & Saakvitne, 1995).

HELPFUL STRATEGIES FOR THERAPISTS

It is expected that trauma therapists will experience some level of general distress, CT, and/or STS, and as noted above, vicarious traumatization easily results when such responses are left unattended (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). We propose several strategies to reduce the risk or ameliorate the negative effects of this work. A holistic approach to dealing with these effects involves first acknowledging them and then addressing their impact both professionally and personally.

Because this work pulls therapists to be introspective and involved in intense feelings that can be quite negative, activities that balance this tunneled view and exposure are vital to helpers' emotional health. Numerous publications by experienced therapists have suggested specific strategies to help therapists help themselves, including Cunningham (2004a), Ryan (1999), Friedrich (1990), Fike (1990), McCann and Pearlman (1990), Medeiros and Prochaska (1988), Nader (1994), Neumann and Gamble (1995), and Pearlman and Saakvitne (1995). These include the following professional and personal strategies.

1. *Pursue training and professional activities that promote learning*, such as professional continuing education programs related to both trauma and children. Trauma therapist should have specialized training in trauma theory and its impact. This training not only increases their understanding of traumatized clients, but may also decrease the deleterious effects of the work on the therapists themselves (Danieli, 1994; Pearlman & Saakvitne, 1995; Yassen, 1995). Trauma theory "offers intellectual containment in the face of violence and [the] powerlessness/helplessness it can engender," as well as "an anchor to assist with feelings or affect" (Yassen, 1995, p. 198).
2. *Work with a variety of clients, and limit exposure to trauma in general.* Each trauma case can take an emotional toll on a therapist; the effect is cumulative and can become increasingly difficult to deal with when the therapist is attempting to handle several cases at once. Exposure to trauma can also be limited in other ways, such as by adhering to personal guidelines about movies, recreational reading, and television. Because violent and potentially traumatic material is now widely available via the mass media, such self-imposed limits are unfortunately becoming necessary.
3. *Maintain rejuvenating relationships and experiences.* Relationships that provide love, care, warmth, and compassion can be essential to helping therapists feel connected to the world and supported in daily events and feelings. Exercise and other mind–body activities can help therapists achieve distance from their intense work-related feelings and difficult thoughts.
4. *Create boundaries between home and work, and maintain a personal identity.* Therapists must draw a line between their work and their personal and private space. Although the demands of therapists' jobs often require homework, it is important to limit this and to enter a physical and psychological space that is safe, comforting, and different from the trauma. Telephone boundaries are important, and phone calls between sessions should be kept within specified time limits. It is

not easy for therapists to tell clients that their time is restricted, but this is essential for therapists to rejuvenate themselves so that they can be there for clients during the sessions.

5. *Find professional friends who understand the stress of trauma work and who will be available for support.* Social support buffers work-related stress (Ursano & Fullerton, 1990; Fullerton, McCarroll, Ursano, & Wright, 1992). Talking about disturbing imagery or other details to a trusted confidant is also useful. A person who can hear such details and respond empathically to the therapist may provide enough support to enable the therapist to let go of them. Some therapists may be reluctant to share their reactions to trauma work because of concerns about confidentiality or because they perceive these reactions as unprofessional responses. "One is not 'unprofessional' if haunted or preoccupied by the pain of one's clients" (Gamble, 2002, p. 347). As noted earlier, STS or vicarious traumatization that goes unaddressed has toxic effects on the therapist: It is personally painful and can interfere with the ability to provide effective treatment (Pearlman & Saakvitne, 1995).

Ideally, an agency should organize a group to attend to the psychological needs of therapists who work with traumatized children and families. This group should be sensitive to therapists' needs for sharing, continuing education, case conferences, and limits on the number of trauma cases. If the agency cannot arrange an official group, then a brown-bag lunch meeting can serve as a way for therapists to talk about their reactions to the work. Research on stress management (Boscarino et al., 2004) has confirmed that a lack of group support exacerbates therapists' stress. In contrast, a supportive environment that validates and responds to therapists' perceptions, feelings, and needs enables the therapists to tolerate more severe stress (Geller, Madsen, & Ohrenstein, 2004; Perry, 2002).

6. *Spend time with children who have not been victimized, to maintain perspective on typical child behavior and normative development.* This participation is enjoyable for the therapist and helps expand his or her own ability to play.

7. *Engage in activities that promote a sense of efficacy and empowerment.* Neumann and Gamble (1995, p. 346) note that "the cynicism and over-generalized negative beliefs about humanity that signal vicarious traumatization must be actively challenged." Some therapists find it helpful to become politically active, in order to address the trends and policy issues that perpetuate violence in our society. For many therapists, political action and community involvement provide concrete ways to feel effective.

8. *Confront and work through intrusive traumatic imagery.* There are several ways to lessen the impact of intrusive images (Pearlman & Saakvitne, 1995). Identifying the underlying needs and cognitions associated with the trauma is a useful way to step back from the powerful imagery. For example, a therapist who cannot let go of a violent image associated with a crime or event may notice that his or her sense of immediate safety has been challenged. Building in a conscious representation of safety or creating a new ending to a story, and shifting the thinking to this image, can be useful. Also, at the end of a session a therapist can imagine a giant fish net filtering through his or her brain, collecting all the horrific images. The captured material can then be balled up and "sent out to sea,"

or put in an imaginary trunk under lock and key (J. Williamson, personal communication, 2006).

9. *Engage in personal psychotherapy*. As noted previously, self-knowledge is crucial for therapeutic work. Unknowingly and unwittingly, traumatized clients pull at therapists' most vulnerable personal attitudes and beliefs. Helpers who lack an understanding of themselves and have not worked through the feelings associated with their own vulnerabilities are more likely to be closed off to the dynamics evoked in these therapies, or even to label and blame traumatized child clients as "bad" or "difficult" children. Such therapists may be less likely to believe in the process and possibility of psychotherapeutic change, and they may be more likely to remain in patterns of their own dysfunction. In addition, it is essential for therapists who have personally experienced trauma to work through as much of this as possible, so to avoid getting "triggered" by their past traumatic histories.

10. *Seek supervision from therapists experienced in trauma work*. Supervision or consultation can be a powerfully positive experience that can address the feelings associated with trauma work and help counter professional isolation (Webb, 1989). Pearlman and Saakvitne (1995) recommend seeking a supervisor who (a) demonstrates theoretical grounding in both therapy and child development; (b) acknowledges and works with both conscious and unconscious processes in trauma treatment; (c) has an understanding of CT and parallel process; and (d) has an awareness of and sensitivity to the potential for vicarious traumatization.

It is helpful when agency administrators make a commitment to the professional development of their staff with the provision of ongoing training in trauma work and good supervision. However, this can be difficult within an environment that emphasizes increased productivity and managed care restraints (Cunningham, 2004b).

Some therapists may seek support in ways that are inappropriate (Cunningham, 1999, 2004a, 2004b). Therapists need a safe place to discuss their reactions to the work and process them effectively and professionally. We believe that trauma-related supervision and personal therapy are the most appropriate outlets. Supervisors or therapists working with traumatic issues need to be aware of the effects of trauma work and to be supportive and nonjudgmental. Supervision/consultation time should be scheduled on a regular basis (Cunningham, 2004b).

SPIRITUALITY AND MINDFULNESS

The disruptions in a therapist's spiritual framework that accompany vicarious traumatization may be the most painful effects of trauma work with children (Pearlman & Saakvitne, 1995). Spirituality may buffer therapists from these deleterious effects, such as questioning the meaning of life, asking why humans suffer, losing hope and idealism, and becoming disconnected from others (Pearlman & Saakvitne, 1995). Spiritual beliefs and practices may help therapists find a way to transcend the pain they face each day in their sessions with traumatized children, and to access a place of calmness despite the tumultuousness of life (Silf, 1999).

However conceptualized, "spirituality" includes any attempt to connect to that which is beyond an individual. This may be accomplished through traditional spiritual paths (such as meditation, prayer, participation in a spiritual community, and rituals), or through nontraditional activities that create a connection to a purpose in life or a sense of sacredness. Examples of such a connection are a deep commitment to nature, to humanity, or to living a compassionate and meaningful life.

The spiritual practice of "mindfulness" is helpful both within the context of clinical work and in dealing with the effects of it. Mindfulness is the practice of "cultivating some appreciation for the fullness of each moment we are alive" (Kabat-Zinn, 1994, p. 3). This allows the therapists to tap into the wellspring of their inner most wisdom (Carroll, 2004). In treatment, mindfulness helps therapists be in the moment, fully attentive to clients and their here-and-now experience. Likewise, it can help therapists balance work life with personal life. When therapists are in session, their attention is focused on their clients and the material the clients are presenting in the moment. However, when therapists are not in session, their attention is ideally on those they are with and the task at hand. And in periods of solitude, mindfulness can assist therapists in being aware of their own needs. Mindfulness helps therapists focus on and appreciate all aspects of life, including what they may see, hear, touch, smell, and taste in their surroundings. So, by practicing mindfulness, they remember to bring their full attention to the task at hand (Cunningham, 2004a). (For a more detailed description of spirituality and mindfulness as buffers for vicarious traumatization, the reader is referred to Cunningham, 2004a).

CASE EXAMPLE

Donna, Karen, Fran, Matt, and Nicole had all graduated from the same school of social work within the past 2 years. They knew each other and decided to seek group consultation. The group had met twice a month for the past 6 months, and although the members all worked in separate places as clinical social workers, each worked therapeutically with children and families.

- Donna worked in an inner-city elementary school where she could see children in therapy with parents' permission.
- Karen provided services to preschoolers and families who came for day care.
- Fran was the primary therapist for adolescents in a residential treatment facility.
- Nicole saw children presenting with mood disorders, trauma, aftereffects of parental divorce or other losses, and behavior disorders in the local community service agency.
- Matt was a crisis worker and conducted small groups for middle school boys with social difficulties.

Today Karen was presenting. Typically, within each 90-minute group session, two presenters spoke for 30 minutes each; the remaining 30-minute period was used by the consultant and other members.

Content of Session	*Rationale/Analysis*
KAREN: This week 4-year-old Tommy was found playing "touch" with a 4-year-old girl classmate. This was the third time he has been caught in inappropriate touching. Each time was followed with clear discussions about physical boundaries, and Tommy appeared to get it that he shouldn't touch other kids in genital areas. The teacher was getting exasperated with him and told me he might have to leave the day care center to protect the other children. I am seeing Tommy individually in play therapy. Over the past 2 weeks he has been enacting sexual scenes of kissing, sexual touching, and intercourse with the dolls in therapy. When I asked him directly about his play, he related it to events in the past year when he had been sexually abused by his stepfather. That man was no longer in the home. Tommy's mother is a single mother of two, ages 4 and 2, who works for minimum wage and depends strongly on the agency for child care and other supportive services. The mother has worked hard over the past 2 years to pull herself out of the abusive relationship with Tommy's stepfather. She was abused as a child and only now understands the implications of all of it.	
My concern is how to help Tommy have a therapeutic place in this day care. I know I am very wrapped up in this case.	Delineating concerns for the group to discuss is a helpful way to focus consultation experiences. Karen reveals some awareness of her reactions to the case, which is also helpful.
Tommy is so cute and very sweet, but in the sessions, he transforms.	Karen is attempting to use the relationship to assist Tommy, but recog-

He's playing along with the animals and dolls with me, and before long I become irrelevant to him. Two scenes arise often. First, he plays with the family in the dollhouse, doing usual domestic things. The boy uses the potty, and the daddy comes to the bathroom, giving the boy a bath. Daddy bathes the boy's genitals, the boy gets silly back, and then the play shifts to chaos. The furniture is turned upside down. No one is talking; they are under the furniture, and stuff is almost literally flying in the room. It is hard to find time to say anything to him about it all, because I'm afraid he'll hurl a piece of furniture to hurt me, and because so much is happening so fast! I get stuck in between wanting to put limits on him and wanting to promote the richness of the play.

nizes how the child's capacity to relate to another is not sustained in the play. The play reflects the chaos of Tommy's inner world, which can reflect either the actual events of his life or (more likely) his prevailing affect and reactions to living in the family.

The job of a therapist is to provide a venue for a child to express the difficult material and experiences he or she has endured. However, the therapist also needs to assist the child with affect regulation. If the play becomes out of control, the therapist needs to help the child to calm him- or herself while continuing to play.

CONSULTANT: He is demonstrating his inner life—and it is chaotic. It switches from feeling good to scary in a flash, and he is left in the rubble—just as you are feeling. It is too fast for words and awareness of feeling—but he feels captured, helpless, and in danger, for sure. It's out of control and begging for recognition and containment.

There are many strong and difficult feelings to attend to in working with this little boy. Bearing witness to the graphic stories of this child is indeed a challenge for Karen. The consultant offers support by voicing both realities—that of the child and that of the therapist.

K: Yes, that's right. The other day I couldn't stand it—but also I thought, "He's ready for this." I introduced a policeman. He immediately told me, "No—he can't come."

Karen attempts to provide a policeman as a concrete example of containment. She may also be so acutely aware of Tommy's feelings that she feels helpless herself—potential evidence of STS.

C: It is hard to stand the helplessness of the child facing the situation. Labeling the feelings for Tommy might have been helpful. Tolerating the helplessness of traumatized children can be hard for the therapist, particularly when it regards something you cannot change. Being mindful of this dichotomy—the need for the change,

Tommy's play suggests that he feels stuck with the abuse and the chaos. He has more feelings to express through play. Also, it is important to determine if the policeman figure is a symbol of help in this child's culture. In this situation, the child is not ready for too much

but the difficulty in facilitating it—may assist you in your approach to the teacher, as well as with the child.	containment, and he resists the police. Karen may feel increased tension because Tommy is not ready to put his trauma to rest—and she must continue to bear witness to the issues.
K: In his second recurring scene, Tommy transitions to the sand abruptly. He initiates dinosaur play in a nonaggressive, exploring, and friendly manner. The dinosaurs happily begin wrestling . . . then Tommy gets silly. I reflect the progression of the play and the feelings. I ask if the dinos could ever have this much fun without wrestling or touching. He pulls them apart and they continue in the sand—but the mood becomes boring then, and Tommy finishes. So I see why he touches in class—it is fun and exciting. But I have that critical teacher looming in the back of my head! This poor little guy—he is dealing with so much and she doesn't appear to care. I try to explain, but she keeps espousing the rules. Rules! Rules! Rules!	Karen is doing a good job of seeing the parallel between the play and Tommy's life. She is also frustrated by what she perceives as the teacher's limitations, and wants to protect him from people who cut off his inner life through lack of validation.
C: Yes, you feel exasperated. Could the teacher be feeling that? Could her emphasis on rules be an attempt to protect other children?	The consultant attempts to develop Karen's awareness of the dynamics of her frustration. The rules provide a containment that Tommy also needs. Is Karen experiencing anger with the perpetrator for "starting" the problems? Could her frustration with the child, who challenges the day care rules and safety of other children, be displaced onto the teacher? Is Karen's exasperation a reflection of her helplessness and overidentification, or of the beginning of vicarious traumatization?
K: I suppose. But what about Tommy's needs?	
C: Let's discuss the meaning of the touch for this child before we discuss the rules. Why is he chronically repeating this, even though he appears to cognitively understand that the rule is	Touch, even traumatic touch, can be experienced in multiple ways by the victim. If Karen is not aware of the meanings of the behavior, it is likely that the behavior will be continued.

"*no* touching in private parts"? Could he possibly be seeking some positive physical feelings? Could the stepfather have been a resource for that before, despite the boundary issue?

NICOLE: He could be seeking physical nurturance, but his method is not very adaptive.

DONNA: If he has heard the touch rules so many times, why doesn't he get it? It's like he wants to get in trouble.

K: He has heard them often, but I guess if the inappropriate touch is in part associated with the need for nurturance, perhaps he can't change that behavior until that need gets addressed some other way.

C: Very good point. What ways can you think of?

K: This little boy stays in day care about 12 hours a day. His mom is overwhelmed and exhausted. Not many other family resources. . . . I guess Tommy does have to manage himself without sexual touching at some point. But what do I do? How do I help him stop?

N: What if you talk with him before the play about how important it is to keep all the children in the day care safe? This is supposed to be a place where everyone feels safe. What if you provided him with a special touch pillow and a way to get good nurturance from the teacher? Would the teacher be willing to have special play with him?

FRAN: Could his mom come in for a few minutes to play with him in the morning? Could we help her by giving a note to her job, requesting a later starting time once a week? You, Karen, could model some positive play and talk with her about what is going on . . .

Often cognitive interventions alone do not suffice for children. They have little motivation to change their behaviors, and at this age do not have forethought regarding the behaviors. Behavior change in young children is more successful when the underlying needs are addressed and the children are encouraged to satisfy their needs in appropriate ways.

Pairing the behavior (touching) with the positive nurturance is a good plan, particularly if the behavior has roots in sensory stimulation and attention-seeking needs.

Another good idea: to promote the mother's positive nurturing skills.

K: OK, but what about the teacher? I am not sure she'll be up for a lot of special activities. She is frustrated with Tommy, despite the fact that this little boy really loves her. I have trouble getting her to understand psychological issues. It's not just with Tommy, though; I am working with about four other children in her room who are struggling. It is hard to find her empathy—but she does appear to offer much structure for the children.	Karen is clearly frustrated by the teacher, and because of that may not be acknowledging the strengths she offers the children. Both teacher and therapist may need a break.
MATT: Seems like the rules and structure are very helpful to Tommy.	
K: Yes, but if he gets kicked out because he breaks the rules, that will be very tough for his mom. I worry about him often.	
C: Does your supervisor know about your struggles? Would a meeting with her and the teacher be helpful?	The consultant addresses the difficulty between the teacher and Karen. They may be in a stalemate and need a third person to assist them in getting unstuck.
K: Could be. It would be nice if I didn't feel so alone therapeutically in this family. I think my supervisor could be neutral, but could also understand both of us and facilitate a better communication.	Accepting the ideas of others to try can be difficult when Karen has put so much energy into the family and classroom. She seems receptive to this suggestion, however.
C: I am wondering, too, if you need a break from cases in this classroom. Any way to get some distance on that front?	The consultant reminds Karen of the importance of distance—and boundaries.
K: I am scheduled to go on vacation in a few weeks. I am both excited and frightened that this boy will be kicked out while I am gone. . . .	
D: Perhaps if you can get some of the changes we've discussed in place before you go, your supervisor can cover for you, and Tommy and his mom will take some positive steps.	
K: It's worth a try.	

C: It is very important to take care of yourself and to really get away during vacation. . . . To carry that worry could ruin the positive impact of the vacation. Being away provides a perspective, hopefulness, and freshness that are essential in working with such emotionally draining cases. I hope you will find a way to talk with your supervisor about these issues so you can use the time off to truly relax. What other resources do you have to buffer yourself from these strong feelings in the moment?

The consultant notices how much energy Karen is expending on the case, even when she is not at work, and reminds her to use the vacation to “recharge her batteries.”

K: I like to read poetry when I get away. It helps me both reflect on myself and then get distance. I crave long walks and spending time with my best friend. We talk about the world, our love lives; we laugh a lot, and by the end, my perspective is much better.

C: That’s terrific! You are attending to the many parts of yourself. Here’s to a great vacation!

CONCLUSION

Working with traumatized children may indeed create a plethora of difficult reactions and feelings, which, if left unattended, can have a negative impact on the therapist. However, several authors (Linley, Joseph, & Loumidis, 2005; Arnold, Calhoun, Tedeschi, & Cann, 2005) state, and in fact Kadambi and Ennis (2004) have found data to support, that most professionals are coping well with their work despite its demands.

While we maintain that therapy with traumatized children can be distressing, we must also recognize that the work is very rewarding. As we therapists assist children in coping with and healing from horrific events in their lives, we will often be touched by the resiliency of human nature and the ability to overcome adversity. Our commitment to deal effectively with the real stress of the work frees us to recognize the positive effects the work has on us as well, which can provide us with feelings of efficacy and hope.

Study Questions

1. Discuss why working with traumatized children can be particularly difficult for therapists.
2. To which type of trauma victims do you anticipate having the strongest emotional response? Why? What might you do about that?
3. Describe the difference between STS and vicarious traumatization. Name symptoms of each. Have you experienced any of these?
4. Describe techniques that therapists can use to handle STS and vicarious traumatization. What techniques have you used? Which were most helpful and why?
5. Name some strategies you might use while working with a child or family when you are faced with overwhelmingly difficult information.

ACKNOWLEDGMENTS

The case example is a composite, and efforts have been made to protect anonymity. We would like to thank Erica Weinstein and the social workers at Friends Association for Children for their assistance with clinical material.

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Appendix

Play Therapy Resources

SUPPLIERS OF PLAY MATERIALS

Sunburst Visual Media
(Childswork/Childsplay)
45 Executuve Drive, Suite 201
P.O. Box 9120
Plainview, NY 11803-0760
Phone: 800-962-1141
Fax: 800-262-1886
Website: *www.sunburstvm.com*
e-mail: *info@guidancechannel.com*

Childcraft Education Corp.
P.O. Box 3239
Lancaster, PA 17604-3239
Phone: 800-631-5652
Fax: 888-532-4453
Website: *www.childcrafteducation.com*

Creative Therapeutics
155 County Road
Cresskill, NJ 07626-0317
Website: *www.rgardner.com*
e-mail: *drgardnersresources@yahoo.com*

JIST Life featuring Kidsrights
8902 Otis Avenue
Indianapolis, IN 46216
Phone: 800-892-5437
Website: *www.jist.com/kidsrights*

Magic Cabin
3700 Wyse Road
Dayton, OH 45414
Phone: 800-247-6106
Website: *www.magiccabin.com*

Rose Play Therapy
3670 Travelers Court
Snellville, GA 30039
Phone: 800-713-2252
Fax: 770-760-0624
Website: *www.roseplay.com*

School Specialty
W6316 Design Drive
Greenville, WI 54942
Phone: 888-388-3224
Website: *www.schoolspecialty.com*

Self-Esteem Shop
32839 Woodward Avenue
Royal Oak, MI 48073
Phone: 800-251-8336
Fax: 248-549-0442
Website: *www.selfesteemshop.com*
e-mail: *deanne@selfesteemshop.com*

Toys to Grow On
2695 East Dominguez Street
P.O. Box 17
Carson, CA 90895
Phone: 800-874-4242
Fax: 800-537-8600
Website: *www.toystogrowon.com*
e-mail: *toyinfo@toystogrowon.com*

U.S. Toy Co., Inc.
Constructive Playthings
13201 Arrington Road
Grandview, MO 64030
Phone: 816-761-5900, 800-832-0224
Fax: 816-761-9295
Website: *www.ustoy.com*
e-mail: *ustoy@ustoyco.com*

Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, CA 90025-1251
Phone: 800-648-8857
Fax: 310-478-7838
Website: *www.wpspublish.com*

SELECTED TRAINING PROGRAMS AND CERTIFICATIONS

Play Therapy

Boston University School of Social Work
Postgraduate Certificate Program in Advanced Child and Adolescent Psychotherapy
Candace Saunders, LICSW, Director
264 Bay State Road
Boston, MA 02215
Phone: 617-353-3750
Fax: 617-353-5612
Website: *www.bu.edu/ssw/continue.html*

California School of Professional Psychology
Alliant International University
Dr. Kevin O'Connor, Director
5130 East Clinton Way
Fresno, CA 93727
Phone: 559-456-2777, ext. 2273
Fax: 559-253-2267
Website: *www.alliant.edu*

Chesapeake Beach Professional Seminars
3555 Ponds Wood Drive
Chesapeake Beach, MD 20732-3916
Phone: 410-535-4942
Website: *www.cbpseminars.com*
e-mail: *cbps@sbpsseminars.com*

Fordham University Graduate School of Social Service
Post-Master's Certificate Program in Child and Adolescent Therapy
Dr. Nancy Boyd Webb, Director
Tarrytown, NY 10591
Phone: 914-332-6008
Fax: 914-332-7101
Website: *www.fordham.edu/gss/tarrytown/nbw/*

International Society for Child and Play Therapy/Play Therapy International
Fern Hill Centre, Fern Hill
Fairwarp, Uckfield, East Sussex TN22 3BU, UK
Phone: 44-1825-712360
Fax: 44-1825-713679
Website: *www.playtherapy.org*

New England Center for Sandplay Studies: Sandtray, Narrative and Expressive Arts
Judith Kneen, Director
31 Boston Avenue
Medford, MA 12155
Phone: 781-488-3933
e-mail: *JKneen@bu.edu*

Play Therapy Training Institute
Dr. Heidi Kaduson and Dr. Charles Schaefer, Directors
P.O. Box 1435
Hightstown, NJ 08520
Phone: 609-448-2145
Fax: 609-448-1665
Website: *www.ptti.org*

Rainbow Project
831 East Washington Avenue
Madison, WI 53703
Phone: 608-255-7356
Fax: 608-255-0457
Website: *www.rainbowproject.bizland.com*
e-mail: *Pconklin@therainbowproject.net*

Theraplay Institute
1137 Central Avenue
Wilmette, IL 60091
Phone: 847-256-7334
Fax: 847-256-7370
Website: *www.theraplay.org*
e-mail: *theraplay@aol.com*

University of North Texas
Center for Play Therapy
Dr. Sue Bratton, Director
P.O. Box 310829
Denton, TX 76203-0829
Phone: 940-565-3864
Fax: 940-565-4461
Websites: *www.coe.unt.edu/cpt*, *www.centerforplaytherapy.org*
e-mail: *cpt@coefs.coe.unt.edu*

Vision Quest into Symbolic Reality
Gisela Schubach De Domenico
1946 Clemens Rd.
Oakland, CA 94602
Phone: 510-530-1383
Website: *vision-quest.us/vqisr/trainings.htm*
e-mail: *gisela@vision-quest.us*

Vista Del Mar Child and Family Services
3200 Motor Avenue
Los Angeles, CA 90034-3710
Phone: 310-836-1223, 888-22-VISTA
Fax: 310-204-4134
Website: *www.vistadelmar.org*

Trauma/Crisis Mental Health Counseling

American Academy of Experts in Traumatic Stress
368 Veterans Memorial Highway
Commack, NY 11725
Phone: 631-543-2217
Website: *www.aaets.org*

American Association of Suicidology
5221 Wisconsin Avenue N.W.
Washington, DC 20015
Phone: 202-237-2280
Fax: 202-237-2282
Website: *www.suicidology.org*

ChildTrauma Academy
5161 San Felipe, Suite 320
Houston, TX 77056
Phone: 281-816-5604
Fax: 713-513-5465
Website: *www.childtrauma.org*

Child Trauma Institute
P.O. Box 544
Greenfield, MA 01302-0544
Phone: 413-774-2340
Website: *www.childtrauma.com*

EMDR International Association
P.O. Box 141925
Austin, TX 78714-1925
Phone: 512-451-5200
Website: *www.emdria.org*

National Institute for Trauma and Loss in Children
900 Crook Road
Grosse Pointe Woods, MI 48236
Phone: 313-885-0390, 877-306-5256
Website: *www.tlcinst.org*

Grief Counseling

Association for Death Education Headquarters
60 Revere Drive, Suite 500
Northbrook, IL 60062
Phone: 847-509-0403
Fax: 847-480-9282
Website: *www.adec.org*

National Center for Death Education
Dr. Carol Wogrin, Executive Director
Mount Ida College
777 Dedham Street
Newton, MA 02459
Phone: 617-928-4649
Website: *www.mountida.edu*

CHILD-RELATED AND TRAUMA-RELATED PROFESSIONAL ORGANIZATIONS

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue N.W.
Washington, DC 20016-3007
Phone: 202-966-7300
Fax: 202-966-2891
Website: *www.aacap.org*

American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
Phone: 847-434-4000
Fax: 847-434-8000
Website: *www.aap.org*

American Medical Association
515 North State Street, #16
Chicago, IL 60610
Phone: 312-464-5000, 800-621-8335
Website: *www.ama-assn.org*

American Professional Society on the Abuse of Children
940 N.E. 13th Street
CHO #B-3406
Oklahoma City, OK 73104
Phone: 405-271-8202
Fax: 405-271-2931
Website: *www.apsac.org*

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209-3901
Phone: 703-907-7300
Website: *www.psych.org*

American Psychological Association
750 First Street N.E.
Washington, DC 20002-4242
Phone: 202-336-5510, 800-374-2721
Website: *www.apa.org*

American Red Cross
National Headquarters
2025 E Street N.W.
Washington, DC 20006
Phone: 202-303-4498
Website: *www.redcross.org*

Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202
Phone: 410-547-6600
Website: *www.aecf.org*

Association of Pediatric Oncology Social Workers
c/o June McAtee, LCSW
Children's Healthcare Pavilion
Hematology Oncology Clinic
8300 Dodge Street
Omaha, NE 68114-4114
Phone: 402-955-3951
Fax: 402-955-3972
Website: *www.aposw.org*

Association for Play Therapy, Inc.
2060 North Winery Avenue, Suite 102
Fresno, CA 93703
Phone: 559-252-2278
Fax: 559-252-2297
Website: *www.a4pt.org*

Children's Defense Fund
25 E Street N.W.
Washington, DC 20001
Phone: 202-628-8787
Website: *www.childrensdefense.org*

Children's Group Therapy Association
P.O. Box 521
Watertown, MA 02472
Phone: 617-646-7571, ext. 490
Fax: 617-894-1195
Website: *www.cgta.net*

Children's Witness to Violence Project
Boston Medical Center
91 East Concord Street, 5th Floor
Boston, MA 02118
Phone: 617-414-4244
Website: *www.childwitnesstoviolenceproject.org*

Child Welfare League of America
440 First Street N.W., Suite 310
Washington, DC 20001-2085
Phone: 202-638-2952
Fax: 202-638-4004
Website: *www.cwla.org*

Council for Exceptional Children
1110 North Glebe Road, Suite 300
Arlington, VA 22201
TTY: 866-915-5000
Phone: 888-232-7733
Fax: 703-264-9494
Website: *www.cec.sped.org*

Federal Emergency Management Agency
500 C Street S.W.
Washington, DC 20472
Phone: 202-566-1600, 800-480-2520
Website: *www.fema.gov*

International Society for Traumatic Stress Studies
60 Revere Drive, Suite 500
Northbrook, IL 60062
Phone: 847-480-9028
Fax: 847-480-9282
Website: *www.istss.org*

National Association of Social Workers
750 First Street N.E., Suite 700
Washington, DC 20002-4241
Phone: 202-408-8600, 800-638-8799
Website: *www.naswdc.org*

National Association of Perinatal Social Workers
c/o Irene Bruskin, MSW, Membership Chair
Children's Hospital of New York Presbyterian
3959 Broadway
CHN T757
New York, NY 10032
Phone: 212-342-8594
Website: *www.napsw.org*

CHILD-RELATED AND TRAUMA-RELATED PROFESSIONAL JOURNALS

Child Abuse and Neglect
Elsevier Science, Inc.
360 Park Avenue South
New York, NY 10010-1710
Phone: 212-989-5800
Fax: 212-633-3990
Website: *www.elsevier.com*

Child and Adolescent Social Work Journal
Springer Science and Business Media LLC
101 Philip Drive, Assinippi Park
Norwell, MA 02061
Phone: 781-681-0537
Fax: 781-681-9045
Website: *www.springerlink.com*

Child and Family Behavior
Haworth Press, Inc.
10 Alice Street
Binghamton, NY 13904
Phone: 800-429-6784
Fax: 800-895-0582
Website: *www.haworthpressinc.com*

Child: Care, Health and Development
Blackwell Publishing
350 Main Street
Malden, MA 02148
Phone: 781-388-8200
Fax: 781-388-8210
Website: *www.blackwellpublishing.com*

Child Development
c/o Society for Research in Child Development
3131 South State Street, Suite 302
Ann Arbor, MI 48108-1623
Phone: 734-998-6524
Website: *www.srcd.org*

Child Psychiatry and Human Development
Springer Science and Business Media LLC
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Norwell, MA 02061
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Website: *www.springerlink.com*

Child Study Journal
State University of New York College at Buffalo
Educational Foundations Department
306 Bacon Hall
1300 Elmwood Avenue
Buffalo, NY 14222-1095
Phone: 716-878-4303
Fax: 716-873-5833
Website: *www.buffalostate.edu/educationalfoundations*

Child Welfare (formerly *Child Welfare Quarterly) Journal*
P.O. Box 932831
Atlanta, GA 31193
Phone: 800-407-6273
Website: *www.cwla.org/pub*

Children and Youth Care Forum
Springer Science and Business Media LLC
101 Philip Drive, Assinippi Park
Norwell, MA 02061
Phone: 781-681-0537
Fax: 781-681-9045
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Elsevier Science, Inc.
360 Park Avenue South
New York, NY 10010-1710
Phone: 212-633-3730
Fax: 212-633-3680
Website: *www.elsevier.com*

Children's Health Care
Lawrence Erlbaum Associates
10 Industrial Avenue
Mahwah, NJ 07430
Phone: 201-258-2200
Website: *www.erlbaum.com*

Gifted Child Quarterly
National Association for Gifted Children
1707 L Street N.W., Suite 550
Washington, DC 20036
Phone: 202-785-4268
Website: *www.nagc.org*

Journal of Abnormal Child Psychology
Springer Science and Business Media LLC
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Norwell, MA 02061
Phone: 781-681-0537
Fax: 781-681-9045
Website: *www.springerlink.com*

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Lippincott Williams & Wilkins
351 West Camden Street
Baltimore, MD 21201
Phone: 410-528-4000
Fax: 410-528-4312
Website: *www.jaacap.com*

Journal of Child and Adolescent Group Therapy
Springer Science and Business Media LLC
101 Philip Drive, Assinippi Park
Norwell, MA 02061
Phone: 781-681-0537
Fax: 781-681-9045
Website: *www.springerlink.com*

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Department of Human Services
Malaspina University-College
900 Fifth Street
Nanaimo, British Columbia V9R5S5, Canada
Phone: 250-753-3245, ext. 2685
Website: *www.ucalgary.ca/ucpress*

Journal of Child Psychology and Psychiatry and Allied Disciplines
Blackwell Publishing
350 Main Street
Malden, MA 02148
Phone: 781-388-8200
Fax: 781-388-8210
Website: *www.blackwellpublishing.com*

Journal of Clinical Child Psychology
Lawrence Erlbaum Associates
10 Industrial Avenue
Mahwah, NJ 07430
Phone: 201-258-2200
Website: *www.jccap.net*

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Springer Science and Business Media LLC
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Norwell, MA 02061
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Fax: 781-681-9045
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Phone: 781-681-0537
Fax: 781-681-9045
Website: *www.springerlink.com*

Psychoanalytic Study of the Child
Yale University Press
P.O. Box 209040
New Haven, CT 06520-9040
Phone: 203-432-0960
Fax: 203-432-0948
Website: *www.yale.edu/yup/books/083718.htm*

Trauma and Loss: Research and Interventions
National Institute for Trauma and Loss in Children
900 Cook Road
Grosse Pointe Woods, MI 48236
Phone: 313-885-0390, 877-306-5256
Website: *www.tlcinst.org*

Trauma, Violence and Abuse
Sage Publications Ltd.
6 Bonehill Street
London EC2A 4PU, UK
Phone: 44-(0)20-7374-8500
Fax: 44-(0)20-7373-8600
Website: *www.sagepub.co.uk*

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