Examining the Perspectives of an Interdisciplinary Treatment Team Regarding the Implementation of a Sensory Motor Group Trauma Curriculum in a Child and Adolescent Partial Hospitalization Program

Barbara Peck

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EXAMINING THE PERSPECTIVES OF AN INTERDISCIPLINARY TREATMENT TEAM REGARDING THE IMPLEMENTATION OF A SENSORY MOTOR GROUP TRAUMA CURRICULUM IN A CHILD AND ADOLESCENT PARTIAL HOSPITALIZATION PROGRAM

by

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Submitted in partial fulfillment of the requirements for the degree

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EXAMINING THE PERSPECTIVES OF AN INTERDISCIPLINARY TREATMENT TEAM REGARDING THE IMPLEMENTATION OF A SENSORY MOTOR GROUP TRAUMA CURRICULUM IN A CHILD AND ADOLESCENT PARTIAL HOSPITALIZATION PROGRAM

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Abstract

A trauma curriculum was introduced at a child and adolescent partial hospitalization program. This study examined (a) the impact of the trauma curriculum on the partial hospitalization program; (b) the perspectives of the multi-disciplinary treatment team–teachers, teacher aides, trauma clinicians for the children and adolescents in the partial program, parents/caregivers, the facility's psychiatric nurse, the facility’s medical director, and county program specialists–and a panel of expert practitioners toward the curriculum, and (c) any changes in the perspectives of the multi-disciplinary treatment team concerning the concept of trauma and its effects. To answer the research questions of this qualitative study, an evaluative case study, using an observer-participant, method was used. Focus groups and key informant interviews were conducted to evaluate the perceptions of the multi-disciplinary team. A focus group was held with expert practitioners to ascertain their evaluation of the trauma curriculum. Transcriptions of the audio-taped interviews were evaluated and emerging themes were noted. A total of 34 themes was identified. Using the proceedings of the focus group with the expert practitioners, the themes were subsumed within one or more of three cultural categories–organizational, clinical, and psycho-social. These findings led to several conclusions: (a) the sensory motor curriculum implemented in the trauma groups at a children’s partial program should be continued; (b) the twice-monthly case consultation meetings with the professional staff at the partial hospitalization program should continue with a consultant experienced in the field of trauma; (c) a task force of parents and professional staff should be formed and make recommendations for a parent group to
complement the trauma groups needs to be implemented; (d) improved communications for all staff regarding the structure of the trauma groups and the specific needs of the children and adolescents is needed; and (e) academic programs need to address trauma theory and the effects of trauma in counselor education curricula.
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One of my current clients told me she prayed for “legions of angels” to help me to get this done. I believe those angels surrounded me as I completed this document. When I began my doctoral program, I thought I couldn’t do this, that I shouldn’t do this. But, several “earthly angels” convinced me that I could. I acknowledge all of you who told me I could and I should and that I belonged. Thank you for telling me to “get going!"
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The New Directions staff members are inspiring in the way they rally and respond to the children in their care. Their compassion is evident. The courageous children and adolescents who walked through the doors of New Directions are an inspiration. They and their parents will always be in my thoughts.

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And, one final note: 20 in and 20 out!!!!

xxx
DEDICATION

I wish to dedicate this dissertation
and the degree that is completed with it
to my late parents,
Mary Lu and Hank,
who taught me the value of education;
to Nancy,
who gave new meaning to the word courage;
and to my family,
Andy, Megan, and Hugh,
who provided an abundance of
encouragement, laughter, and support.
CHAPTER I
INTRODUCTION

Children depend on their caregivers, specifically the nuclear family, to provide basic needs including nurturing and predictability (Perry, 2000). It is through family interactions, traditions, rituals, storytelling, music, and religion that the developing child learns the beliefs, values, and meaning of their culture. Parents are the mirror for the infant, providing the foundation of love, acceptance, and encouragement that allow the child to move through the early developmental task of learning trust and achieving the first milestone of healthy development (Cicchetti & Toth, 1995; Maughn & Cicchetti, 2002; Schore, 2002). Perry summed it up this way: “The way a society functions is a reflection of the child rearing practices of that society” (p. 12).

Unfortunately, not all children experience this type of love and nurturing, and many may not have their basic needs—food, clothing, and shelter—met. Children learn about themselves by the way in which their parents or caregivers treat them. When adults are neglectful, uncaring, or abusive, children learn to treat themselves and others in the same manner. This abusive underpinning gets woven into the fabric of family, community, and culture and contributes to violence, erosion of self, and family deterioration (Cicchetti & Rogosch, 1994; Perry, 2000).

The Neglected and Abused Child

The home is where most family violence—battering, killing, and verbal and emotional abuse—occurs. Additionally, emotional abuse often accompanies domestic violence and includes fear of abandonment, feeling unsafe, and being humiliated (Kerig,
These incidences of domestic violence also are referred to as traumatic events. They create a sense of helplessness in the victim and may include either threats on one’s life or bodily injury. Trauma may also involve witnessing violence (Herman, 1997). According to the American Psychological Association, each year, approximately 3.3 million children observe violence by relatives against their mother or female caregiver (Melrose Alliance Against Violence, n.d.).

The human response to trauma has been characterized as one of either fight, flight, or freeze (Herman, 1997; Perry, 1994, 1997; Putnam, 1997; van der Kolk, 1996). This response, based on biological changes in the child’s body and mind, is one over which the child has no control (Bloom, 1995). Trauma can rob a child of the ability to self protect—fight or flee—in that the body goes into a freeze mode in which it cannot respond (Perry, 1994, 1997; Schore, 2002). According to Bloom (1997), traumatic events also diminish the child’s ability to trust and deflate the child’s sense of empowerment.

While natural disasters or automobile accidents can have traumatic effects on an individual or community, those situations normally are not planned or deliberate. Intentionality and deliberateness, however, are components of child maltreatment. Perpetrators of maltreatment remove any power their child victims may have had. Typically, children do not have the physical resources to combat a larger adult. Emotional, verbal, physical, and sexual abuse are personal and can be internalized by the child in various ways (James, 1994; Perry, 1994; Putnam, 1997; Schore, 2002; Siegel, 1999).
Although child abuse is a recognized criminal act, there are varying thoughts as to what constitutes child abuse. Often, a clinician may determine abuse and/or neglect in a child. Social workers, physicians, school counselors, and others involved in the treatment and care of children, while mandated by law to report any instances of suspected child abuse or neglect, are not required to prove or disprove the allegations of abuse or neglect. Once a mandated reporter determines that a child has been abused or neglected, the reporter must complete a Child Protective Service (CPS) report, as federally mandated. As one example, in Pennsylvania, by law, the local Office of Children, Youth and Families (OCYF) is delegated the sole responsibility of investigating Child Protective Service reports. After the investigation, a different determination is sometimes made by the OCYF, perhaps finding that the report is not substantiated. This occurs due to the variables that are assessed by OCYF (Schene, 1998).

In Pennsylvania, many abused or neglected children eventually make their way into alternative educational programs. This study focuses on the plight of traumatized children in a partial hospitalization program in Pennsylvania by examining the effects of a trauma curriculum implemented at the facility. Adults involved with the program in various roles were interviewed in order to investigate the perceived effects of the curriculum on the partial hospitalization program, as well as perspectives regarding the curriculum and the concept of trauma.
Defining Child Abuse

The United States Congress passed the Child Abuse Prevention and Treatment Act (CAPTA), Public Law 93-247 in 1974. CAPTA developed a broad definition of maltreatment that includes:

. . . the physical and mental injury, sexual abuse, neglected treatment or maltreatment of a child under the age of 18 by a person who is responsible for the child’s welfare under circumstances which indicate the child’s health and welfare is harmed and threatened thereby, as determined in accordance with regulations prescribed by the Secretary of Health, Education, and Welfare. (CAPTA, 1974)

Several aspects of the law are relevant for purposes of this discussion. The following legal definitions, as specified in CAPTA (1974), are provided. A child is anyone who is under the age of 18. Abuse perpetrated by caregivers outside of the home is said to be an assault and could involve law enforcement and a criminal offense. However, abuse perpetrated in the home where the child resides is defined as child abuse and neglect. According to the law, physical abuse is an act performed by a caregiver and resulting in physical harm to the child. Physical abuse may include the death of a child. Other examples of physical abuse include kicking, biting, shaking, stabbing, or punching of a child. Spanking is considered disciplinary unless the child is bruised or injured. Sexual abuse is an act performed by a caregiver that is an intrusion or penetration, molestation with genital contact, or sexual acts in which the child is used to provide sexual gratification for the perpetrator. Sexual abuse includes pornography and sexual exploitation. Neglect is an act of commission or omission by a caregiver that involves a
refusal or delay in providing health care; failure to provide basic needs including food, clothing, shelter, affection, and attention; inadequate supervision; or abandonment.

*Emotional neglect* is a caregiver act that involves rejecting, isolating, terrorizing, ignoring, or corrupting a child. Examples of emotional neglect are confinement; verbal abuse; withholding sleep, food, or shelter; exposure to domestic violence; allowing a child to engage in substance abuse or criminal behavior; or refusing to provide psychological care. An essential component of emotional neglect is that it must be sustained and repetitive.

Additionally, the Juvenile Justice Act of 1986 was passed by Congress to have the juvenile justice system conform with the United Nations Standard Minimum Rules for the Administration of Juvenile Justice. This act provides for the care and jurisdiction of neglected and delinquent youth including the removal of neglected and abused children to a facility other than a jail for their safety and protection. Juvenile Court was developed from this law for all proceedings of neglected and delinquent children. On December 30, 2000, the Juvenile Justice Act was revised and is currently the act under which juvenile justice processes cases (Juvenile Justice Act, 2000).

In the United States, the response to maltreated children is directed through the federal government in that the receiving, investigating, and reporting of abuse and neglect cases is assigned to child protective service organizations and/or agencies at the local level. The federal government provides the framework to states via laws and funding. State and county governments then allocate the finances. The child investigating agencies operate under statewide statutes. Additionally, the CPS agencies provide resources, foster
or kinship care, and adoption services to children in need of further protection (Schene, 1998).

*Children’s Services at the Local Level*

Dave Madison, Executive Director for Fayette County Children and Youth, explained that the local OCYF investigation is fact finding in nature and includes 20 factors that are to be evaluated before deciding if a report can be substantiated (D. Madison, personal communication, June 10, 2003). This investigation can be thorough and intrusive, sometimes requiring visits into the family home or schools. Also, it necessitates a working relationship with local authorities, the court system, education systems, social service providers, and mental health agencies.

In Pennsylvania, the Child Protective Services Law, Title 23 Pa. C. S. A. Chapter 63, through the Department of Public Welfare (1975 & 1998) defines child abuse as follows:

(1) The term “child abuse” shall mean any of the following:

(i) Any recent act or failure to act by a perpetrator which causes nonaccidental serious physical injury to a child under 18 years of age.

(ii) An act or failure to act by a perpetrator which causes nonaccidental serious mental injury to or sexual abuse or sexual exploitation of a child under 18 years of age.

(iii) Any recent act, failure to act or series of such acts or failures to act by a perpetrator which creates an imminent risk of serious physical
injury to or sexual abuse or sexual exploitation of a child under 18 years of age.

(iv) Serious physical neglect by a perpetrator constituting prolonged or repeated lack of supervision or the failure to provide the essentials of life, including adequate medical care, which endangers a child’s life or development or impairs the child’s functioning.

(2) No child shall be deemed to be physically or mentally abused based on injuries that result solely from environmental factors that are beyond the control of the parent or person responsible for the child’s welfare, such as inadequate housing, furnishings, income, clothing and medical care.

(3) If, upon investigation, the county agency determines that a child has not been provided needed medical or surgical care because of seriously held religious beliefs of the child’s parents, guardian or person responsible for the child’s welfare, which beliefs are consistent with those of a bona fide religion, the child shall not be deemed to be physically or mentally abused. The county agency shall closely monitor the child and shall seek court-ordered medical intervention when the lack of medical or surgical care threatens the child’s life or long-term health. In cases involving religious circumstances, all correspondence with a subject of the report and the records of the Department of Public Welfare and the county agency shall not reference “child abuse” and shall acknowledge the
religious basis for the child’s condition, and the family shall be referred for general protective services, if appropriate. (pp. 4-5)

*Serious mental injury* is defined as “a psychological condition, as diagnosed by a physician or licensed psychologist, including the refusal of appropriate treatment” (Child Protective Services Law, 1975 & 1998, p. 4), that:

1. Renders a child chronically and severely anxious, agitated, depressed, socially withdrawn, psychotic or in reasonable fear that the child’s life or safety is threatened; or
2. Seriously interferes with a child’s ability to accomplish age-appropriate developmental and social tasks. (p. 4)

The law goes on to define *serious physical injury* as an injury that:

1. Causes a child severe pain; or
2. Significantly impairs a child’s physical functioning, either temporarily or permanently. (Child Protective Services Law, p. 4)

Also, *serious bodily injury* is defined as bodily injury which “creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of function of any bodily member or organ” (Child Protective Services Law, p. 4).

*Sexual abuse or exploitation* is defined as the employment, use, persuasion, inducement, enticement or coercion of any child to engage in or assist any other person to engage in any sexually explicit conduct or any simulation of any sexually explicit conduct for the purpose of producing any visual depiction, including photographing, videotaping, computer depicting or
filming, of any sexually explicit conduct or the rape, sexual assault, involuntary
deviate sexual intercourse, aggravated indecent assault, molestation, incest,
indecent exposure, prostitution, statutory sexual assault or other form of sexual

According to the Child Welfare League of America, in the year 2000, nearly three
million children in the United States were referred for possible abuse and neglect through
the Child Protective Services. Of that number of referrals, 879,000 cases were
substantiated, and 1,236 children died as a result of child abuse or neglect (Child Welfare
League of America, 2003). In Pennsylvania in the same year, 2000, 22,694 cases of abuse
and neglect were reported and investigated by local Offices of Children, Youth and
Families. The county offices of Children, Youth and Families were able to determine
from their evaluations that 5,002 cases were substantiated, and 38 children died of child
abuse or neglect (Child Welfare League of America). In Fayette County, a rural area in
southwestern Pennsylvania, in 2002, a total of 364 referrals was made, 79 of which were
substantiated (Madison & Andria, 2003). Of the 79 substantiated cases, four child
fatalities resulted (Madison & Andria). This number of deaths equates to a rate of 5.1% of
all substantiated cases and compares poorly to the statewide average in which the number
of fatalities was less than 1% of all substantiated cases (Madison & Andria). It should be
noted that only Philadelphia, the most highly populated county in Pennsylvania and an
urban area, had a higher percentage of fatalities than Fayette County (Madison & Andria).

The overall rate of substantiated child abuse cases in Fayette County was 21.7% in
2002. This rate was 1% above the statewide average (Madison & Andria, 2003). Data on
the percentage of substantiated cases of sexual abuse in both Pennsylvania and Fayette County were available for the years 1999, 2000, and 2001. In 1999, Fayette County percentages were slightly less than the statewide average. In 2000, the percentage of substantiated cases in Fayette County exceeded the statewide average of substantiated cases, but only by a small margin. However, in 2001 the average of substantiated cases of sexual abuse in Fayette County was close to 65%, while the statewide average was less than 50% (Madison & Andria).

In Fayette County, there has been an increase in the average number of cases opened for service between 2000-2001 and 2002-2003 which converted into an increase of 28%. Of the accepted cases in Fayette County, the increase in numbers has been attributed to an increase in drug use by both parents and children. A total of 38% of the accepted cases in 2002 was drug-related. Also, there was an increase of 260% in the number of psychiatric hospitalizations and placements in residential treatment facilities for children under OCYF care in Fayette County (Madison & Andria, 2003).

It must be noted that unfounded cases of abuse and neglect means that the reports were not or could not be substantiated or may have fallen outside the statute of limitations. It does not mean that the abuse did not occur. It also needs to be stated that the existing statistics address the number of cases reported and do not necessarily include the actual number of incidents. On the other hand, cases of false allegations for abuse also have been made.
The atrocities of child abuse usually keep professionals focused on the victim, and the indirect effects of maltreatment are not always considered. Heineman (1998) presents the concept this way:

However when the abused child goes to school and hits his classmates at the least provocation, they too become victims of child abuse. The teacher whose self-esteem declines when that child repeatedly thwarts and ridicules her genuine efforts to reach him also sustains the effects of child abuse. When that child grows up and routinely mistreats coworkers and those who would befriend him, they, too, become indirect victims of child abuse as do the partners of women who, because of the sexual abuse they suffered as children, cannot fully enjoy the pleasures of sexual intimacy as adults. (p. 12)

Background of the Problem

In this research, trauma refers to human-made or relational trauma rather than natural disasters or critical incidents. Trauma refers to the experience of a single incident or repeated incidents, either recent or from the past, such that the experience is overwhelming, out of the control of the individual, sudden, and not within the realm of normal daily events. A sense of terror, helplessness, and danger is experienced by the individual whose world view and sense of self can change based on the trauma (Carlson & Dalenberg, 2000; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision), 2000; Herman, 1997).

The field of psychotraumatology—the study of psychological trauma—initially focused on adults, particularly white combat veterans. Later, it also included rape victims,
holocaust survivors, prisoners of war, battered women, and abused children (Herman, 1997; van der Kolk, 1996; Yelunda & McFarlane, 1995). Post Traumatic Stress Disorder (PTSD) was initially described as a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.) (*DSM*) in 1980. There was no separate diagnostic category for PTSD for children. Although the *DSM* has undergone several revisions, there still are no separate diagnostic criteria for childhood PTSD.

“Much of the impetus for the development and integrated understanding of the effects of trauma on social, psychological, and biological functions” (van der Kolk, Weisaeth, & van der Hart, 1996, p. 60) has come from the involvement of individuals who experienced trauma. The initial focus of trauma was on combat veterans or prisoners of war (POWs). This narrow perception of trauma was changed by Burgess and Holstrom’s landmark study (1974) in which they identified the “rape trauma syndrome.” Their research revealed that victims of rape displayed symptoms similar to those of soldiers suffering war neurosis (Bloom, 1997; Burgess & Holstrom, 1974; Herman, 1997; van der Kolk, Weisaeth, & van der Hart, 1996).

In 1955, two physicians, Wooley and Evans confronted their colleagues in the medical profession for ignoring the fact that “multiple injuries” in children were often done intentionally (ten Bensel, Rheinberger, & Radbill, 1997). From 1956 through 1961, C. Henry Kempe and his peers in Denver, Colorado began research on various aspects of child maltreatment. In 1958, he organized a child protection team in Denver; two additional teams were located in Los Angeles and Pittsburgh. These teams identified children who were being abused by their parents and began family intervention programs.
As program chairman for the American Academy of Pediatrics in 1961, Kempe arranged a multi-disciplinary conference on “The Battered Child Syndrome.” As a result, he received national attention. Grants, research opportunities, and conferences regarding child abuse began to occur. From his work, Kempe advocated and obtained support for laws regarding mandated reporting by health professionals concerning suspected child abuse (ten Bensel et al.).

Treating traumatized children can be challenging. Over the past 20 years, research on the effects of trauma on child development has increased (Pynoos, Steinberg, & Goenjian, 1996); yet, there is minimal research to determine treatment interventions with positive outcomes for children (Briere, 1992; Cicchetti & Rogosch, 1994; Cohen, Perel, De Bellis, Friedman, & Putnam, 2002; Glaser, 2000; Putnam, 1997). Research has indicated that childhood trauma increases the likelihood that an individual will develop various psychiatric symptoms and disorders over time (Bloom, 1997; Cicchetti & Rogosch, 1994; Perry, Pollard, Blakley, Baker, & Vigilante, 1996; Putnam, 2003; Schore, 2002). Research also has indicated that many children sustain more than one type of trauma, a situation which can complicate the investigation of the aftereffects of trauma (Maughan & Cicchetti, 2002; Putnam, 2003). For example, a child might witness domestic violence and also endure verbal and physical abuse. This could lead to a change of living situation–going to a shelter, removal by child protective services, being sent to live with a relative, or having a parent removed by authorities from the home–for the child.
Developmental Neurobiology

Perry (1994, 1999a) and Schore (2002) have provided a developmental neurobiological perspective of trauma that has contributed to an increased understanding of the effects of trauma. Neurobiology refers to the manner in which neurons work, how the brain functions and develops, and the developmental aspect of “interpersonal relationships” as it connects to the developing brain (Siegel, 1999). To explain further, the infant-caregiver relationship is a gene-environment relationship where “the mother mediates the external environment of the child, and in dyadic affective transactions she psychobiologically influences the infant’s production of hormones and neurohormones in the infant’s developing nervous system” (Schore, 1994, p. 526). Recently, researchers (Putnam, 1996; van der Kolk, 1996) identified a variety of neurobiological abnormalities in traumatized children and adolescents. These abnormalities included the dysregulation of the neuroendocrine systems and problems with thyroid functions, growth hormones, and sex hormones. Another manifestation of trauma in children and adolescents is the inability of emotion to serve as a cue in assessing incoming information and cause the child/adolescent to reasonably respond. Trauma also is exhibited in cardiovascular difficulties such as increases in heart rate and blood pressure (De Bellis & Putman, 1994; Nemzer, 1998; Perry, 1994, 1999a; van der Kolk, 1996).

Statement of the Problem

Few clinicians are trained to work with trauma victims. This is due, in large part, to the absence of course work related to trauma and its effects in graduate programs such as counselor education, social work, and psychology (Bloom, 1995; Giller & Vermilyea,
2000; Kitzrow, 2002). Chu (1998) commented this way: “Mental health professionals are not routinely trained to detect either covert trauma or dissociation” (p. 40). Many of the clinicians who deal with trauma are self taught in the area of trauma. They review the research of others, attend specialized conferences, consult with others in the field of trauma, and actively participate in trauma-oriented professional organizations.

*Developmental Psychopathology*

Resources for clinicians and clients are limited. Cohen et al. emphasized the importance of improving the “availability of high quality specialized training for professionals treating traumatized children” (2002, p. 104). Sharon Sutton, the clinical coordinator at Pittsburgh Action Against Rape (PAAR), the largest rape crisis center in Western Pennsylvania, stated that one reason for the delay of services to many of PAAR’s clients is the difficulty in finding trained therapists with Master’s degrees in counseling, social work, or psychology who also understand the complex impact of trauma on adults as well as children (personal communication, March 2, 2003). In the 1980s Chu (1998) explained this dilemma in the following way:

However, there was no real awareness of the magnitude of the problem or the long-standing effects of early abuse and neglect. Even residency programs in psychiatry and graduate training in psychology offered little information about how childhood abuse can affect adult mental functioning. It has only been in the past 10 to 15 years that both public and professional attention has been drawn to this issue. (p. 9)
In 1998, the National Association of State Mental Health Program Directors unanimously passed a policy statement indicating that responding to the behavioral health care needs of men, women, and children who experienced trauma from violence was important for the treatment and recovery of those individuals and should be a priority of state mental health programs. This initiative could have implications for mental health centers in improving the training of their clinicians and in the training and curricula offered in graduate schools of counselor education and social work programs. In 2001, the American Medical Association (AMA) took similar action when they required child psychiatry residents to be instructed in the identification and management of domestic and community violence as it affected children and adolescents (Cohen et al., 2002).

This need for training in the area of trauma effects was reinforced by Cicchetti and Toth (1995) who emphasized that “developmental principles be incorporated into the training of researchers and clinicians interested in child maltreatment” (p. 561). In order for this to be accomplished, they encouraged academia to broaden the curricula and improve the integration of developmental theory into psychopathology and training courses in order to enhance the competence of therapists and researchers interested in the area of child abuse and neglect.

**Effects of Trauma**

Repeated traumatic experiences have developmental, neurodevelopmental, emotional, behavioral, and social consequences. The aftereffects of trauma on children include flashbacks, dissociation, hyperactivity, hyperarousal and hypervigilance. These symptoms often go unnoticed because the untrained clinician may not understand what is
happening with the child (Chu, 1998; James, 1994). In schools, children often are labeled as having behavioral problems and subsequently diagnosed with ADHD (Attention Deficit Hyperactivity Disorder) when, in fact, their behaviors are connected to severe or violent traumatic histories (Giller & Vermilyea, 2000; Hannaford, 1995; James, 1994; Perry et al., 1996; Putnam, 1996; Steele & Raider, 2001). While not manifesting into a clear PTSD diagnosis, the observed aftereffects of traumatic experiences can develop into other disorders—ADHD, Bipolar Disorder, Conduct Disorder, or Oppositional Defiant Disorder—over time (Cicchetti & Rogosch, 1994; Perry et al., 1996; Terr, 1991). This is because those involved in diagnosing children typically do not assess for trauma and lack appropriate skills in this type of assessment. Additionally, in many cases, children do not meet the diagnostic criteria for PTSD listed in the DSM-IV-TR since those criteria have been established for adults (Putnam, 1996).

Since September 11, 2001, events in our country have shaken our collective sense of safety. Through the media, the phenomena of trauma have unfolded in front of our eyes. Certainly, this was a national critical incident. Many children and adults also have experienced personal traumas related to the events of September 11, 2001. According to the Twin Towers Orphan Fund (TTOF), more than 1,000 children lost one or both of their parents as a result of 9-11 and are eligible for financial assistance from this fund (Twin Towers Orphan Fund, n.d.). The lives of these children will be changed forever, not only because they lost a parent, but because it was the result of the worst act of terrorism against our country. This event has become a part of our history and will be remembered and referred to in schools, churches, and the media. If any of those children had survived
prior traumatic events, complications, such as the development of PTSD and other psychiatric disorders, could be expected (Perry, 1994; van der Kolk, 1996).

**Purpose of the Study**

Schools are generally considered institutions where children are educated and learn life skills. They are certainly places where children spend much of their time. Schools are expected to teach children in spite of special needs or behavior problems. “Educators, then, must face what becomes an intolerable burden–how to educate children who are disturbed, distracted, hyperaroused and whose behavior often interferes with their own learning and the learning of others” (Bloom, 1995, Abstract, ¶ 1). Learning can most effectively occur when the environment is physically and psychologically safe (Bloom). As a result, alternative schools and programs have been developed to meet the various needs of students when those needs cannot be met by regular schools. For example, partial hospitalization programs with an educational component are in place for those students with serious mental health problems. Such programs could include students with disruptive behaviors and students who are unable to function in special education classes in the public school system. “Traumatized, overstimulated children cannot learn their schoolwork in the hyperaroused state which inevitably accompanies and follows trauma. They cannot calm themselves down and tend to overreact to even minor stimuli” (Bloom, 1995, Knowledge is Power section, ¶ 1).

The purpose of this study is to examine the perspectives of a multi-disciplinary treatment team regarding the inclusion of a trauma-specific curriculum within a local child and adolescent partial hospitalization program. This is important in relationship to
trauma because a clinician’s understanding of trauma guides the approach the clinician takes in the treatment process. This, in turn, has an impact upon the delivery of services to the children in the program. Typically, talk therapy alone will not initiate changes in children who are in treatment. Alternate interventions, however, can be helpful. Expressive arts, movement, and dance are examples of alternate interventions that are not usually addressed in traditional academic settings. Through the case consultation meetings and training sessions with the staff, I provided information concerning alternate treatment approaches that could be used with the children.

**Research Questions**

This inquiry addresses three research questions: (a) How did the trauma curriculum affect the child and adolescent partial hospitalization program at New Directions in Perryopolis, Pennsylvania? (b) What are the perspectives of the multi-disciplinary treatment team–professional staff, parents/caregivers, and county program specialists–and expert practitioners toward the trauma curriculum at the New Directions partial hospitalization program? and (c) Have the perspectives of the multi-disciplinary treatment team–professional staff, parents/caregivers, and county program specialists–changed concerning the concept of trauma and its effects?

Focus groups with the staff at a partial hospitalization program and individual interviews with key informants, including the administrator and psychiatric nurse, were conducted as a means to obtain data for the research. Two focus groups that included parents or caregivers of children who participated in the trauma groups were held in order to explore their understanding of trauma and determine their awareness of their children’s
participation in the groups. Key informant interviews were conducted with a staff member from the Mental Health/Mental Retardation office that serviced the partial hospitalization program and a representative of the insurance company that provided the health insurance coverage for county residents whose children were in the program and also were Medicaid recipients. The purpose was to obtain the perspectives of professionals closely involved with the curriculum as well as those who monitor the program “from a distance.” The findings from the focus groups and individual interviews are presented in Chapter IV.

Since Pittsburgh, Pennsylvania was the closest major city to the county in which the investigation occurred, an additional focus group was held with the Pittsburgh Professional Society for the Study of Trauma and Dissociation (PPSSTD). This group, which consists of expert practitioners interested in treating traumatized individuals, reviewed and critiqued the curriculum. The findings that emerged from those interviews also are reported in Chapter IV.

Theoretical Framework

Developmental psychopathology is one of the theoretical perspectives that anchors this study. This perspective incorporates information from various areas of study–psychology, sociology, psychiatry, and neuroscience–to improve the understanding of normal and abnormal human development. The approach explores development over several domains of functioning including affect, cognition, interpersonal relationships, school adjustment, and biology (Cicchetti, 2002; Cicchetti & Rogosch, 1994). Developmental psychopathology is a working model through which the numerous results
of child trauma can be organized and explained (Cicchetti, 1984, 2002; Cicchetti & Toth, 1995; Putnam, 1997). Research has indicated that the effects of trauma are relative to the age of the child, the history of the child before the trauma, the intensity and frequency of the trauma, and the type of trauma experienced (Cicchetti & Rogosch; van der Kolk, 1996).

Another theoretical perspective that drives this study is developmental neurobiology. According to Siegel (1999), neurobiology is “the study of the way neurons work and how the brain functions” (p. 9). The study of neurobiology has contributed an increased understanding of the effects of trauma and has helped to explain what occurs in the brain as it develops and the resulting relationship to the observed symptoms that result from maltreatment (Perry, 1994, 1999a; Schore, 1994, 2002).

Heineman (1998) stresses that the genetic makeup of the developing brain and the child’s environment influence each other and are in a “constant state of flux” (p. 64). Several researchers (Giller, 1999; Perry, 2000; Schore, 2002; Teicher, Andersen, Polcari, Anderson, & Navalta, 2002) have asserted that trauma has a greater impact on younger, developing brains than it does on adult brains, those that are organized at the time of trauma.

Exposure to repeated traumatic events, which includes witnessing violent acts, has emotional and biological implications (Perry, 1994, 1995, 2000; Teicher et al., 2002). The body’s stress response involves the release of brain chemicals, corticosteroids, including adrenocorticotropin and epinephrine that interfere with brain development, particularly when the victimization is repeated and chronic (Perry, 1994, 2000; Perry et al., 1996;
Teicher et al., 2002). In turn, the chronic or repeated release of brain chemicals affects learning and emotional regulation (Hannaford, 1997; James, 1994; Perry, 1994, 2000; van der Kolk, 1996).

Affect regulation, the way an internal emotion is externally expressed and managed, is problematic in maltreated children (Shore, 1994; Siegel, 1999). This most problematic of trauma symptoms interferes with functioning in many domains including home, school, and community. Traumatic events affect learning and establishing relationships and prevent children from self soothing—having the personal resources to calm themselves in a healthy manner (Perry, 1999a; Shore, 2002). Chronic and repeated exposure to traumatic experiences permanently changes the way in which an individual manages daily routines and affects how one adapts to future stress (Perry et al., 1996; van der Kolk, 1994).

Although researchers have begun to recognize the role neurobiology plays in the development of a child’s brain, “few studies have examined directly any aspect of neurobiology in neglected children. The reasons include a lack of capacity, until the recent past, to examine the brain in any non-invasive fashion” (Perry, 2000, p. 15).

Based on three studies involving traumatized children or adolescents, Terr (1991) identified four general characteristics that can be observed in traumatized children of any age and at any point in the child’s illness. These four characteristics are “1) strongly visualized or otherwise repeatedly perceived memories, 2) repetitive behaviors, 3) trauma-specific fears, and 4) changed attitudes about people, aspects of life, and the future” (p. 12).
Other researchers (Bloom, 1997; Heineman, 1998; Herman, 1997; Marold, 1998; Perry, 1994, 2002; Putnam, 1996; Schore, 2002) have determined that chronic trauma results in affect dysregulation, sleep disorders, startle reactions, sensory motor dysfunction, learning problems, relationship issues, anxiety and panic attacks, and avoidance of specific situations or events. These symptoms, individually or in combination, result from child maltreatment and negatively affect child development (Cicchetti & Toth, 1995; Perry et al., 1996; Putnam, 1997); however, the presentation of one or more of these symptoms does not necessarily indicate that the child has experienced a traumatic situation. Child maltreatment is the foundation from which psychiatric disorders, including depression and separation anxiety, evolve over time (Perry, 1994; Perry et al., 1996; Putnam, 1997; Schore, 2002, Siegel, 1999). It is also known that witnessing or listening to abuse or observing the aftermath of domestic violence can be traumatic for children (Kerig et al., 2000; Rossman & Ho, 2000). In fact, between 30% and 60% of all cases of partner battering also involve the abuse of the partner’s children by the perpetrator (Child Welfare League of America, 2003; Kerig et al.; Rossman & Ho).

The above theoretical perspectives offer a broad frame in which to consider the aftermath of traumatic stress on children and adolescents. These neurobiological, psychological, and developmental aspects are interconnected and will be elaborated on in Chapter II.
Background of the Research Problem

A children’s partial hospitalization program is a day treatment program that provides an intense level of care without the cost of inpatient treatment and allows for intense clinical assessment and intervention (Grizenko, 1997). The structure of day treatment programs varies extensively depending on the setting—hospital, community, or school. The populations which these programs serve vary from those with developmental delays to those with severe and persistent emotional and behavioral disturbances. Treatment approaches also differ and include behavioral and psycho-dynamic techniques (Kiser, Culhane, & Hadley, 1995; Kutash & Rivera, 1996). In order to be admitted to a partial hospitalization program, a child must not be a threat of harm to self or others and must remain at home while receiving the intense level of care provided by the program (Kutash & Rivera). The partial program is designed to manage a variety of mental health issues that are interfering with a child’s ability to be in her/his home school. Partial hospitalization programs are usually community-based and include both an educational component and a mental health component.

Nationally, the average number of children enrolled in long-term partial hospitalization programs is 25 per program (Kiser et al., 1995). At the partial program where the study occurred, the total enrollment was 70 students and included three levels of instruction and mental health interventions—elementary, middle school, and high school (New Directions, personal communication, 2003).
Within the mental health sector in Pennsylvania, there is a continuum of services available to children and adolescents. The least intrusive level of care is outpatient service, which includes weekly, biweekly, or as-needed appointments in a mental health center or private agency. School-based, mental health services are offered in many school districts where a trained mental health therapist is at the site. The school-based mental health therapist is responsible for assessment, intervention, consultation, and collaboration with other school officials to help identify school children at risk of academic failure based on mental health concerns. There are a number of children with mental health concerns who are not able to function in a regular setting—the home, the school, or the community. Behavioral Health Rehabilitation Services (BHRS) provides a higher level of care that is more intrusive and more intensive. BHRS is a family-driven, team approach which allows mental health professionals to provide in-home services to work collaboratively with parents to help their children achieve success. A higher level of care is the Family-Based Mental Health Program. A team of professionals trained in family therapy provides in-home services to the entire identified family for a prescribed number of hours each week. There are two restrictive environments that provide services to children and adolescents—residential treatment facilities and inpatient psychiatric hospitalization. Residential treatment facilities are structured, out-of-home residential placements that can occur outside of the child or adolescent’s community, offer comprehensive mental health interventions for extended periods of time, and require family involvement with a psychiatrist supervising. Inpatient psychiatric hospitalization is
a short-term, out-of-home placement in a locked facility in which professionals address behavior that could result in harm to self or others. Partial hospitalization programs are designed for the child to remain with their family or caregiver and attend a specialized intensive mental health program with an educational component. Children enrolled in partial hospitalization programs can receive other community-based mental health services including family-based mental health or BHRS services (Kutash & Rivera, 1996).

While inclusion in the mainstream educational structure is ideal, some children simply are not able to function in regular schools, even in learning support or special education classes, due to the severity of multiple situations. These situations may include the likelihood of harming oneself or others or having serious emotional disorders. Partial hospitalization programs work in cooperation with the student’s home school in order to meet the student’s mental health needs, as well as strengthening the student’s academic performance, with the ultimate goal of preparing the student to return to her/his home school. The professional staff includes full-time psychiatrists and therapists who are responsible for meeting the student’s mental health needs; full-time teachers and aids give the student academic support. Many of the children have emotional outbursts that escalate, requiring that the child have a timeout, be removed from the classroom, or be physically restrained by qualified staff members. Although many of the children receive psychotropic medications, yelling, swearing, name calling, throwing or breaking objects, hitting, kicking, biting of self or others are disruptive behaviors that continue to be observed and reported by staff members. Most of the children cannot regulate their
behavior nor self-soothe themselves in order to recover from these emotional outbursts. These problems require that staff members be able to respond immediately, without discussing their interventions, in order to assist students in regaining self-control. Teamwork is essential in any mental health treatment setting; it is especially significant within a partial hospitalization setting. The treatment modalities within a partial hospitalization program include family therapy, individual therapy, and group sessions to address a multitude of clinical concerns which may include peer pressure, behavioral difficulties, social issues, and academic concerns (Grizenko, 1997).

Entry into the Program

I was initially invited by the medical director to present a day long in-service for the clinical staff and teachers to increase their awareness of the impact of trauma on children and to increase their clinical skills in working with children and adolescents in a partial hospitalization program. After that training, I was asked to consult with the medical director and her staff on a case-by-case, bimonthly basis. An educational component was incorporated into this process by providing psycho-education regarding the various aspects of the theory and treatment of trauma as it pertained to the individual cases that the staff presented during this consultation. As the consultations progressed, I was requested by the director to develop a trauma curriculum to address two major areas: a) to train the clinical staff to run the specialization groups using a specific curriculum intended for children and adolescents with trauma histories and b) to ameliorate the behavior problems and symptoms experienced by the children and adolescents with known trauma histories.
Description of the Sensory Motor Curriculum

The trauma curriculum was designed to be used with groups of children or adolescents attending a partial hospitalization program. Basic to all of the groups was an introduction to sensory motor exercises intended to provide improved coping skills to assist with self-regulation and to provide healthy outlets for overwhelming emotions. The sensory motor exercises include three of the 26 Brain Gym® exercises developed by Paul Dennison, an educator who has an interest in and passion for children with learning disabilities and developmental delays (Hannaford, 2000). His program utilizes specific movement exercises that can be used in various settings with different levels of behavior severity in order for children to improve learning and increase self esteem. He based his program on the research results from the fields of “sensory-motor training, applied kinesiology, and developmental optometry—relating the effects of movement to learning” (Hannaford, 1995, p. 113). The three exercises selected are referred to as PACE (Positive, Active, Clear and Energetic) and were organized by Carla Hannaford. These exercises are further described in Chapter III and include Brain Buttons, the Pretzel, and Cross Crawls.

Several components of the curriculum were presented to the children’s and adolescents’ groups. The first was a teaching piece that enhanced the children’s and adolescents’ knowledge of trauma and its aftereffects. This is referred to as psycho-education. The second component was the inclusion of social skills that encouraged sensitivity and mutual respect between the students. Third, expressive arts were used to provide a safe avenue for self-expression. Fourth, movement, including three Brain Gym® exercises, was used to allow the students to express themselves
creatively. Other examples of movement included drawing, “target practice,” and “brain mapping.” Music was incorporated into the adolescent groups as a further means of allowing the students to self-soothe and express themselves.

The trauma curriculum was written with consideration for the specific population of the partial hospitalization program in which the study was conducted. Most of the children (not the adolescents) in the program could not read nor write. The staff consisted of predominantly bachelor-level clinicians. I trained the staff as they rotated through the trauma groups. They participated as the co-leaders with me. Fifteen minutes immediately following each session were set aside for the purposes of discussion and debriefing. Suggestions provided by the staff were incorporated into the curriculum. The groups were not intended to overwhelm the students; rather, they were designed to teach the children and adolescents techniques they could use to calm down when overcome with emotions or when anxious about situations in other areas of the program or in other domains. The curriculum was designed to be flexible and yet meet the varying needs of the participants. Each of the groups was structured, yet the students were provided the opportunity and encouraged to process what had occurred in each of the group sessions. The curriculum provided hands-on interventions designed to maintain the attention of the children and encourage their involvement while providing exercises they could do to help with self-soothing and regulation of emotional outbursts in areas of their lives outside of the groups—the home, the transportation vehicles, and other areas of the partial hospitalization program.
The curriculum was intended as an introduction to trauma and did not require participants to disclose their personal trauma experience to the group unless they chose to do so. The curriculum included a component of psycho-education regarding trauma and the use of creative arts to express individual trauma responses. A developmental sensory motor approach was used in creating this curriculum due to the fact that a proportion of the children had learning disabilities impairing their reading and writing skills. Many of the students had short attention spans and were restless. Their behavior is consistent with the research (James, 1989; Perry, 1999a) which states that children internalize their responses to trauma and can describe body sensations such as “tied in knots,” “insides that shake like jell-O,” and “scared.” In view of these challenges, I developed the sensory motor curriculum to meet the varying needs of the children and adolescents.

Significance of the Study

Partial hospitalization programs are used throughout Pennsylvania and other parts of the United States. The children and adolescents enrolled in these programs often are unable to understand the reasons for their emotional outbursts or self-soothe themselves following their outbursts. The curriculum developed and implemented at the research site was designed to assist students in these areas. This research was conducted in order to determine the appropriateness of the curriculum.

The perspectives of the multi-disciplinary treatment team regarding the trauma curriculum were investigated. The curriculum incorporated a sensory motor focus using trauma theory in a partial program that utilizes a predominantly behavioral approach. The trauma theory was woven into the trauma curriculum, which was then implemented in the
trauma groups. The trauma focus encouraged the children and adolescents to become aware of their bodies and body sensations to identify when they felt they were becoming emotionally overwhelmed. By increasing their self-awareness, each individual could implement the activities and exercises learned in the groups to increase self-care and to improve their academic learning and concentration.

The curriculum was in part co-created in collaboration with the staff and structure at the partial hospitalization program in which the study was conducted and, indirectly, by the responses of the children and adolescents. Over time, this process allowed the curriculum to meet the needs of the participants.

*Importance of Assessing Trauma*

It is important that clinicians dealing with children and adolescents embrace a more extensive assessment that includes a trauma component that will improve the efficiency of their clinical interventions in order to treat this under-served and mis-diagnosed population. According to Marotta (2000), accountability in the service provided is one way for the counseling profession to be recognized. This also includes knowing the standards of care set by other mental health professionals and staying current through continuing education. Experts in the trauma field have identified psycho-education as an essential intervention in treating traumatized individuals and their caregivers (Chu, 1998). Additionally, the study of human development is part of the counselor education curriculum. This approach can be complemented by knowledge about traumatic stress (Marotta, 2000).
Scope and Delimitations of the Study

There are several delimitations of this study. Although a curriculum focusing on children is at the center of this study, children were not included as participants in the study. I felt that they constituted a highly vulnerable population, and that there was a possibility that some children could be re-traumatized, especially given the nature of the questions that would be directed at them and the focus that would be placed upon them. As a professional dedicated to the safety and well-being of children, I deduced that the therapists, teachers, parents, and other professionals involved in the implementation of the curriculum could represent the children well and could efficaciously speak to the impact that the trauma curriculum had on the partial program. It is important to emphasize that this study was conducted with adults who interacted with traumatized children. This research was conducted with a contained adult population, one which dealt with children and adolescents for whom a specific trauma curriculum had been designed. The adults included the medical director, the psychiatric nurse, the teachers, the clinicians, the parents, two county representatives, and the expert practitioners in the study group.

Overview of the Dissertation

This first chapter provides an overview of the problem being studied. The second chapter provides a review of the literature in several areas—an overview of the history of trauma, a review of the last 10 years concerning the treatment of traumatized children, attachment theory, developmental psychopathology, neuro-development, Brain Gym®,
risk factors, and an overview of current trauma curricula and treatment interventions for children and adolescents.

The third chapter describes the methodology used by the researcher in conducting the study. It includes a description of the design, rationale, participants, data collection, and the manner in which the analysis was conducted. The fourth chapter focuses on the results of the data analysis taken from five focus groups and three key informant interviews. A narrative data analysis of the interviews and focus groups, including the themes and cross-case analyses, is provided.

The fifth chapter includes an overview and discussion of the research results and findings, the limitations of the study, and suggestions for future research. The appendixes contain a glossary of definitions used in this research, a copy of the consent forms that were signed by the participants, a copy of the follow-up letter, a copy of the focus group questions, and the transcription of one focus group.
CHAPTER II
REVIEW OF THE LITERATURE

Overview

This chapter contains a review of the literature in several areas that are relevant to the research reported in this document. These areas include: (a) an historical view of trauma; (b) the history of Post Traumatic Stress Disorder (PTSD) and Dissociative Disorders as included in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, their relatedness, and their differences; (c) a discussion of relational trauma and the human stress response; (d) attachment theory; (e) the theory of developmental psychopathology as it relates to maltreatment; (f) the contribution of neurobiology in understanding both the effect of maltreatment on the brain and external effects observed in children; (g) other risk factors, including poverty, pertaining to the population studied; and (h) an overview of interventions for the treatment of children and adolescents exposed to traumatic events.

Historical Perspective of Trauma

Historically, the “systemic study of psychological trauma” has depended on the support of political movements (Herman, 1997, p. 9). Herman provided three examples from the last two centuries when an aspect of trauma has come to the attention of the general public through political avenues.

*Hysteria*

The first example involves the study of hysteria, the “psychological disorder of women.” In 19th century France, a battle raged between the established monarch, who
was influenced by the Catholic Church, and supporters of the republican secular government. In 1870, the Third Republic, the secular government, was in operation and intended to decrease the power of the Catholic Church so that democracy could thrive. One of the leaders of this group was Jean-Martin Charcot, a French neurologist who changed a large asylum known as the Salpêtrière where the insane, the poor, and prostitutes were maintained. Charcot revamped the institution “into a temple of modern science” (Herman, 1997, p. 10). To his credit, Charcot studied hysteria and provided the residents with a safe environment that included protection from their familiar experiences of violence. He presented “Tuesday Lectures,” during which he demonstrated his findings concerning the women of the asylum. During his lectures, the women occupied the stage with him. These lectures were the popular place to be and were attended by physicians, writers, theater people, and curiosity seekers (Herman).

Pierre Janet and Sigmund Freud were among the neurologists and psychiatrists who came to Salpêtrière to study hysteria with Charcot. Charcot used his own drawings, writings, and photographs to emphasize the symptoms of hysteria and symptoms that indicated neurological problems such as seizures, sensory losses, paralysis, and amnesia. He reinforced the importance of precise observations, descriptions, and classifications. He did not interact with his patients about their internal processing or the details of their traumas. By 1880, he showed that the observed symptoms were psychological in nature since the use of hypnosis decreased their intensity (Herman, 1997).

After the death of Charcot, Janet and Freud competed to find the reason or reasons for hysteria. During the next 10 years, Janet and Freud discovered similar factors. They
both interacted with their patients on a daily basis and agreed that psychological trauma was the basis for the hysteria. Overwhelming emotional responses to trauma created an altered state of being for their patients. Janet referred to this as “dissociation,” while Freud called it “double consciousness” (Herman, 1997). Through their clinical experiences, Janet and Freud learned that once their clients could put words to their memories and emotions, the symptoms decreased.

Janet believed that the “dissociation” was about individual weaknesses in that those who dissociated were different from normal people. He believed that the emotional reaction was so intense, it could not be incorporated as memory and, thus, remained unprocessed (Putnam, 1996; van der Kolk, 1996). Freud disagreed. Initially, he stated that childhood sexual abuse was the basis of the hysteria. Later, he recanted this theory when he realized the social implication of his position—that children were being sexually assaulted in epidemic proportions—and reported that the hysteria was based on the client’s fantasy (Herman, 1997).

Unfortunately, political situations changed and the need to further investigate trauma in women was no longer applauded or supported. The political environment ceased to support Freud’s research on hysteria (Herman, 1997).

Combat Neurosis

The second event that brought trauma to the forefront by way of a political movement was the “neurosis” suffered by combat veterans after World War I and World War II (Bloom, 1997; Herman, 1997). When World War I ended, hospitals were filled with veterans experiencing a disorder which was termed “shell shock” by Charles Myers,
a psychologist from Britain (Herman). The number of veterans with combat neurosis or shell shock was alarming and required the establishment of additional hospitals. Abram Kardiner, a psychiatrist who worked with veterans, was distressed by the severity of their symptoms and equated those symptoms to the description of hysteria. In 1941, Kardiner wrote a book, *The Traumatic Neurosis of War*, about the symptoms he had observed (Herman).

Politically, soldiers were overlooked after World War I; they were considered an “embarrassment” (Bloom, 1997; Herman, 1997). However, World War II brought about major changes in psychiatry, including two important beliefs—first, that environmental stresses influenced emotional maladjustment and, second, that intentional supportive interactions could be effective in changing psychological outcomes (Bloom). These changes in philosophy led to increased connections with combat units and their leaders, as well as a greater availability of supplies, hot food, and clean clothes (Grob, 1991).

Two psychiatrists, Appel and Beebe, agreed that combat exposure from 200 to 240 days would have an effect on any human and concluded that mental health problems were inevitable in combat. They reported that soldiers would “break down” in direct relation to the intensity and duration of their exposure (Herman, 1997). Once again, the altered state of consciousness issue was raised, only this time it concerned men at war having the same experiences as the women with hysteria. Because of the attention paid to combat soldiers, it can be said that the focus of social psychiatry evolved from World War II.
The Vietnam War brought about an entirely different scenario. While the war was ongoing, soldiers met in “rap groups” (Herman, 1997; van der Kolk, 1996) to support each other in disclosing their war experiences and subsequent reactions. The discussions in these groups also raised awareness regarding the effects of war. Established Veteran Outreach Centers provided staff members to facilitate the discussion groups and the accommodations for holding the meetings. Psychiatrists were also invited to attend the meetings. However, the veterans led the discussions (Herman; van der Kolk).

The Women’s Movement

The third political event to affect the study of psychological trauma was the Women’s Liberation Movement of the 1970s. The movement supported consciousness-raising modeled after the Vietnam veterans’ rap groups. In their support groups, women disclosed histories of domestic violence, rape, and incest. Until then, women were unable to collectively speak about the trauma they lived. Their disclosures allowed them to overcome shame and, more importantly, be believed.

The primary outcome of the support groups was social reform. Using the groups as a means of collecting data and organizing, the women’s movement generated a plethora of research on sexual assault. Additionally, pressure from the movement’s members caused the National Institute for Mental Health to develop a research center for the study of rape (Herman, 1997). Rather than being identified as a sexual act, rape was acknowledged as a crime of violence (Herman). This categorization of rape led to increased responses to victims. One such response was a grassroots campaign that
resulted in the creation of rape crisis centers where victims of sexual assault received legal as well as emotional support (Herman).

Two researchers, Ann Burgess, a psychiatric nurse, and Lynda Holmstrom, a social worker, investigated the psychological effects of rape while working at the Boston City Hospital in 1972 and interviewed 92 women and 37 children. The symptoms exhibited by the women they studied were similar to those experienced by combat veterans—sleep disturbances, startle responses, nightmares, flashbacks, and dissociation (Herman, 1997). As a result of their work, Burgess and Holmstrom identified the “rape trauma syndrome” (1974). The adult female subjects in their study, collectively, reported rape as a life threatening event which they also associated with the fear of mutilation (Herman).

Prompted by the women’s movement, researchers and female activists focused their attention on domestic violence and the sexual abuse of children. As was true with rape, the initial investigations on domestic violence and child abuse led to a rediscovery of the syndrome of psychological trauma (Herman, 1997). Herman likened the trauma of rape, domestic violence, and the sexual abuse of children to the trauma experienced by combat victims:

Only after 1980, when the efforts of combat veterans had legitimated the concept of post-traumatic stress disorder, did it become clear that the psychological syndrome seen in survivors of rape, domestic battery, and incest was essentially the same as the syndrome seen in survivors of war. The implications of this insight are as horrifying in the present as they were a century ago: the subordinate
condition of women is maintained and enforced by the hidden violence of men. There is war between the sexes. Rape victims, battered women, and sexually abused children are its casualties. Hysteria is the combat neurosis of the sex war.

(p. 32)

The Study of Childhood Trauma

In the early part of the 19th century, poor, abandoned children were placed in almshouses alongside criminals, the mentally ill, and homeless adults. These facilities had minimal standards of care. By the middle of that century, private agencies and religious organizations established orphanages. As a result of these actions, some states instituted laws necessitating the transfer of children from the almshouses to orphanages (Schene, 1998). Clinical reports written about the children in these 19th century orphanages stimulated the awareness of trauma effects existent at that time. The reports spoke of multiple traumas including the loss of one or both parents, separation from siblings, and abandonment (Putnam, 1997). The reports alluded to learning problems and developmental delays.

It was not until after World War II, however, that awareness of the impact of trauma on children started to become clear. This was due, in part, to the research of René Spitz who studied institutionalized children diagnosed with depression. Spitz’ work had a “profound impact on the field of child development in general and on the field’s understanding of the effects of maltreatment in particular” (Putnam, 1996, p. 22).

Reacting to accusations that the medical profession had, for years, ignored incidences of multiple injuries to children and the possibility that the injuries had been
committed willfully, Denver pediatrician Henry Kempe began to study the many facets of child abuse. In 1958, Kempe headed one of the first child protection teams in the nation. These teams recognized the role parents played as abusers and were influential in the creation of treatment programs for families (ten Bensel, Rheinberger, & Radbill, 1997).

In 1961, Kempe was serving as the program committee chair of the American Academy of Pediatrics. In that capacity, Kempe organized a multi-disciplinary conference entitled “The Battered Child Syndrome.” Several important actions resulted from that conference. First, the initial model of the child abuse law was drafted. Second, a journal article with the same title as the conference was written following the conference. The article, co-authored by a multi-disciplinary group, contained the results of a survey of district attorneys who reported that a large number of children had been severely beaten. The article was the first of its kind to alert medical professionals on a national level of the effects of child abuse. It eventually led to a law requiring physicians and other medical professionals to report suspected cases of neglect and child abuse (ten Bensel et al, 1997). By 1968, all states had mandatory reporting laws for medical and other health professionals.

Fueled by the women’s movement, researchers began to delve into the maltreatment of children, particularly in family settings. However, it was not until 1975 that Richard and Cathy Kempe (1978) conducted the first systematic research on maltreated children and violence in the family.

As late as 1980, the leading textbook on psychiatry in the United States claimed that incest—a violent act committed against children in a family setting—had occurred to
fewer than one in one million women and, therefore, was not particularly damaging
(Kaplan, Freidman, & Sadock, 1980, as cited in van der Kolk, Weisaeth, & van der Hart,
1996). Several subsequent research studies that focused on incest contradicted that
assertion.

In 1986, sociologist Diane Russell conducted a study of 930 women from various
socioeconomic and cultural backgrounds. The women were randomly selected from the
general population as opposed to being selected from a clinical population. While
one-third of the women reported histories of childhood sexual abuse and one-half of the
sexual abuse reports were identified as incestuous in nature, two-thirds of the incest
survivors were later raped. One-fourth of the 930 subjects reported being raped
(Chu, 1998; Herman, 1997).

After hearing repeated histories of incest from adult female patients with
borderline personality disorders, psychiatrist Judith Herman became convinced that the
occurrence of incest was far greater than that reported in the literature. She then
researched the “nature and undeniable harmful effects of sexual violation” (Chu, 1998,
p. 11) and found incest to be far more common than previously believed. Her work
resulted in Father-Daughter Incest, a book which Chu described as “stunning” and a
“scientifically credible” work (Chu, p. 11; van der Kolk, 1996).

Other research on families and the maltreatment of children focused on the
infant-caregiver relationship. In the 1950s and 1960s, Bowlby conducted research that
later led to the psychological Attachment Theory, which provided an understanding of the
importance of the relationship between the infant and the caregiver and the effects of
traumatic events on development (Cicchetti, Toth, & Lynch, 1995; Siegel, 1999). Bowlby’s theory ascribed to the fact that the infant internalizes the experiences with the attachment figure—usually the mother—and creates an “internal working model” (Steele, 1997, p. 76).

Bowlby’s work was supported by the more recent work of Schore (2001) who contends that an infant gets a great deal of stimuli from the caregiver’s face. The mother is the regulation agent and, by her responses and facial expressions, particularly those of the eyes, regulates the affect (emotion) in the child. The biological connection of the mother and child and the visual and auditory communications between them are also important. Research indicates that the mother and child match their emotional states and adjust social attention, stimulation, and accelerating arousal to each other’s responses. The mother and child create what Schore (2001) calls an inner psychophysiological state which is regulated by both the mother and child. Schore applauded John Bowlby for his work on attachment theory, calling Bowlby the “most important scientist of the late twentieth century to apply an interdisciplinary perspective to the understanding of how early developmental processes influence later mental health” (Schore, 2001, p. 5).

While a variety of events could, potentially, have traumatic effects on children, the leading cause of trauma in children is child maltreatment (Putnam, 1996). It is exhibited as a variety of symptoms and maladaptive behaviors which directly affect child development (Putnam). The chronic traumatization in children “deforms the personality” (Herman, 1997, p. 96) and creates changes in the development of the child’s personality (Chu, 1998).
DSM Classifications

The primary document used for the diagnosis and classification of mental disorders is the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, currently in its fourth edition (text revision). The *DSM-IV-TR* includes several diagnostic categories which are trauma-related. Two of these are Post Traumatic Stress Disorder (PTSD), which is under the classification of anxiety disorders, and Dissociative Disorders.

Post Traumatic Stress Disorder was introduced as a new diagnostic classification under the anxiety disorders in the *DSM-III* (APA, 1980). With the inclusion of PTSD in the *DSM-III*, the psychiatric community recognized the relationship of trauma to psychopathology (Peterson, 1998). It is the only diagnosis in the *DSM* that is determined by the situation; that is, one is affected internally by an external event (Terr, 1991; Tinker & Wilson, 1999).

According to the *DSM-IV-TR* (APA, 2000), PTSD is presented with 17 symptoms grouped in three categories. The diagnosis of PTSD stipulates that three types of symptoms—re-experiencing, avoiding or numbing, and hyperarousal—occur following a traumatic situation. The duration of these symptoms is greater than one month. The criteria for PTSD was originally established for the adult population. For the first time, exclusions for children were identified in the *DSM-IV*.

The *DSM-IV-TR* (APA, 2000) defines a traumatic event (Criterion A1) as: direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event
that involves death, injury, or a threat to physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. (p. 463)

Examples of traumatic events are also listed in the DSM and include, among others, torture, kidnaping, sexual assault, robbery, severe vehicular accidents, child maltreatment, terrorism, being captured as a prisoner of war, car jacking, natural disasters, having a life threatening illness or medical condition that warrants invasive medical procedures, witnessing violent acts including the murder or assault of others, domestic violence, and the sudden death or serious injury of a family member or close friend. It should be noted that not everyone who experiences a traumatic event develops PTSD, nor will most traumatized individuals need ongoing treatment (Carlson & Dalenberg, 2000; Carrion, Weems, Ray, & Reiss, 2002; Chu, 1998; Levine, 1997; Scaer, 2001). However, it has been estimated that 20% of the individuals who experience traumatic events will develop PTSD (Rothschild, 2000).

In the 1980 edition of the DSM-III, dissociative disorders were recognized as a separate classification. The diagnosis “dissociative reaction” had been included in the first edition of the DSM (APA, 1952). That diagnosis was changed to “hysterical reaction, dissociative type” in the second edition, DSM-II (APA, 1968; Putnam, 1996). In the latest edition, DSM-IV-TR, five dissociative disorders—Dissociative Amnesia; Dissociative Fugue; Depersonalization Disorder; Dissociative Identity Disorder (DID), previously known as Multiple Personality Disorder (MPD); and Dissociative Disorder, Not Otherwise Specified (DDNOS)—are defined (DSM-IV-TR, 2000; Putnam, 1996).
Both of these disorders—PTSD and Dissociative Disorders—are defined for the adult population in both the *DSM-IV* (APA, 1994) and the *DSM-IV-TR* (2000) with exclusions or considerations for children and adolescents indicated. Carrion et al (2002) reported that a “developmentally sensitive assessment of symptoms after trauma may be more valid than the *DSM-IV* criteria in very young children, because symptoms of PTSD may differ substantially between children and adults” (p. 167). The research of Carrion et al produced results that led these researchers to call for an improved method of diagnosing pediatric PTSD by assessing the intensity of the exhibited symptoms and their relation to functional impairment. The research results of Scheeringa, Peebles, Cook, and Zeanah (2001) also validated the need to modify the *DSM-IV* criteria for PTSD from a developmental viewpoint. These researchers suggested reducing the number of required Cluster C symptoms, which pertain to avoidance and numbing, from three criteria to one. Currently, for children and adolescents to be diagnosed with PTSD, they must meet the adult criteria. As a result of the need to meet the adult criteria, researchers in the area of child and adolescent trauma (Cohen & Deblinger, 2002; Tinker & Wilson, 1999) have stated that PTSD is under-identified and underrated.

Adult PTSD was first included in the *DSM* in 1980. In all probability, it will take even longer for pediatric PTSD to be included in the manual (Pfefferbaum, 1997). Tinker and Wilson (1999) stated that “until the definition is changed, we will continue to underestimate the incidence and prevalence of PTSD in children” (p. 35). They also submitted that clinicians who are unaware of the effects of trauma incorrectly allocate trauma-related symptoms to other diagnoses and categories not related to trauma. These
problems with the definition of trauma for children and adolescents contribute to PTSD being discounted in the pre-adult population (Tinker & Wilson).

Research statistics regarding the prevalence of PTSD in children and adolescents varies over a wide range of values. The National Center for PTSD fact sheet reported that between 15% and 43% of all girls and between 14% and 43% of all boys encounter one traumatic experience. Of that number, between 3% and 15% of the girls and between 1% and 6% of the boys “could” receive a PTSD diagnosis (Hamblen, n.d.).

Some studies have been done in the area of chronic abuse as it relates to children and adolescents. Research indicates that chronic abuse may lead to major depression and anxiety disorders in children and adolescents. While chronic abuse and neglect can have a pervasive impact on the psychological and biological regulatory processes in children, PTSD does not necessarily develop (Glaser, 2000; Teicher, Andersen, Polcari, Anderson, & Navalta, 2002; van der Kolk et al, 1996).

At some point in their lives, 51% of all women and 61% of all men in the United States are exposed to trauma. Yet, PTSD is reported as approximately 5% of the general population for women and 10% of the general population for men (Chu, 1998). Statistics for the occurrence of PTSD in children are not readily available, yet researchers agree that children and adolescents could be at greater risk than adults in developing PTSD (Carrion et al, 2002). Because of the lack of solid information, more research needs to be done in the area of childhood PTSD. Yehuda and McFarlane (1995) stated that more exact information is needed to establish specific aftereffects of trauma and further research is
required to identify additional factors that contribute to the development of PTSD in children.

**Psychological Trauma**

For the purposes of this study, focus will be placed on relational or psychological traumas versus traumas associated with critical incidents and disasters. Typically, psychological or relational trauma is intentional and interferes with any sense of empowerment an individual may have. It can instill a sense of disconnection from self, others, and the environment (Herman, 1997). Psychological trauma includes witnessing violent acts, experiencing physical or sexual abuse, being neglected, living through a car accident, undergoing invasive medical procedures, being held captive, being a prisoner of war or a victim of war atrocities, being separated from one’s primary caretakers, experiencing divorce, or going through the death of a loved one or close friend. In general, trauma can be described as “overwhelming, uncontrollable experiences that psychologically impact victims by creating in them feelings of helplessness, vulnerability, loss of safety, and loss of control” (James, 1989, p. 1).

Traumatic events affect individuals in different ways. Not all individuals who experience traumatic events become traumatized nor will two individuals who experience the same traumatic event necessarily react in the same manner—one may become traumatized by the event and the other may not (Cicchetti & Rogosch, 1994; Levine, 1997; Perry, 2001a, 2001b; Perry, Pollard, Blakley, Baker, & Vigilante, 1996; Teicher et al, 2002).
Culture of Trauma

In 1980, the American Psychiatric Association legitimized psychological trauma and trauma effects by including Post Traumatic Stress Disorder as a diagnostic category in the *DSM-III* (deVries, 1996). By their action, the APA encouraged a greater focus on the process of illness with a foundation in an individual’s socio-cultural interaction with the “person’s experience and the meaning which he or she assigns to it” (deVries, p. 399). The human relationships that encircle a child from infancy through adolescence support the child as he or she develops physically and emotionally. Culture frames all of this and provides meaning to daily routines and bestows traditions, values, rituals, religion, and socialization to children and their families (Lewis & Ippen, 2004). Through socialization, culture is learned by language and daily routines. Culture even defines what encompasses trauma.

In the social theory literature, trauma culture is a concept used by several authors to denote a violent situation that affects the lives of the those within the culture. The culture of trauma refers to the manner in which a social group collectively experiences trauma, with each individual having a role as a victim, perpetrator, or spectator (Curran, 2004). Culture determines what constitutes traumatic threat and directs the interpretation of situations. Culture also affects how group reactions are expressed (Lewis & Ippen, 2004; National Association for School Psychologists [NASP], 2003; The Utah Multi-Cultural Legal Center, n.d.). The moral basis of a culture establishes the laws and policies regarding trauma whether it occurs in the home or community or is a group trauma such as a natural or man-made disaster.
Other writers refer to the trauma culture as a “culture of complaint” (Withuis, n.d.), referring to the emphasis placed on victims. Sztompka refers to “the damage inflicted by major social change on the cultural, rather than the biological, tissue of society” (2000, p. 450). He continues the explication by stating that the collective agency, which is the driving force of social change and the history of the culture’s past adaptation to social change, has an effect on the culture as a whole.

Trauma, on a cultural level, is usually a rapid, sudden, and radical process, touching the core of the culture. Typically, the trauma is perceived as coming from an external source to which the collective (members of the culture) has not contributed and is “perceived as shocking, repulsive and unpredicted” (Sztompka, 2000, p. 452). Examples of cultural trauma include, but are not limited to, slavery, The Holocaust, revolutions, genocide, terrorism, war, the 9/11 strikes on New York and Washington, D.C., and natural disasters. In these instances, the protective nature and daily predictability that accompanies culture is shattered, leaving individuals on their own to regain control (deVries, 1996).

Several authors agree that a culture often rehabilitates itself on a framework of cultural customs and values (Andermann, 2002; NASP, 2003; Sztompka, 2000; deVries, 1996). For example, two South American cultures survived traumas of violence. In one of the communities, the members relied on their healers and spiritual leaders; their focus was on strengthening the community. In a different community, the individual focus was taken using a psychological approach to deal with shame and guilt (Andermann).
The Utah Multi-Cultural Legal Center (n.d.) states “Whatever our cultural backgrounds, one thing seems true: Cultural references and identity shape how we identify the threat of traumatic events, interpret them, and manifest our distress at them.” Gusman et al (n.d.) state that the “ability to treat trauma victims is enhanced when the clinician fully integrates an appreciation of cultural differences” (p. 439). They further indicate that “extreme traumas of isolation, terror and fear of death emphasize the coming together of social, moral and political issues in the minority experience of victimization” (p. 439).

Although not new, a cultural effect is seen in the increase in war-torn countries that contributes to children being further exposed to traumatic situations and some children and families having to move to another county for safety, thus increasing the number child refugees and the possibility of experiencing further traumatic events or stressful situations. There also has been an increased awareness of the effects of children witnessing community and domestic violence (Lewis & Ippen, 2004).

This speaks to the importance of clinicians learning about, as well as respecting, the client’s culture. Clinicians need to utilize alternative as well as traditional interventions to complement a client’s culture (Graham-Berman & Halabu, 2004; Lewis & Ippen, 2004; Lieberman & van Horn, 2004). This reinforces the need to have various ways to approach trauma within a cultural context. Because one approach does not work for all, a variety of approaches are needed.

Minimal research has been done concerning the effects of trauma on cohorts of children, which is now starting to be identified. This type of trauma usually is a one-time
incident or occurs over a short time frame and involves either human intention or is a natural disaster. This directly affects the specific children involved and their caregivers. Often, much attention is given to these instances, and the public responds in a positive, supportive manner with services, finances, and needed items. For instance, Bruce Perry assessed and studied all of the children who survived the Branch Davidian trauma in Waco, Texas. Another example is the group of children left orphaned after 9/11 (Lewis & Ippen, 2004; Perry, 1994). “Culture is an underutilized resource in trauma work. Children are more than the passive recipients of cultural socialization. Their responses and needs help to shape the response of the caregiving environment” (Lewis & Ippen, 2004, pp. 39-40).

**Human Stress Response**

Levine (1997) views trauma from a somatic perspective and avers the importance of the body-mind connection. He contends that “body sensation, rather than intense emotion, is the key to healing trauma” (p. 12) and goes on to say that “until we understand that traumatic symptoms are physiological as well as psychological, we will be woefully inadequate in our attempts to heal them” (p. 32). He holds the perspective that healing can be affected by increasing the internal awareness of one’s body. Furthermore, Levine says that trauma cannot readily be described by words and is accompanied by an “intensity that defies description” (p. 47).

Hyperarousal and/or hypervigilence are examples of the toll trauma takes on the body and mind. Gaining an understanding of “how the brain and body process, remember, and perpetuate traumatic events holds many keys to the treatment of the traumatized body
and mind” (Rothschild, 2000, p. 5). Rothschild writes that “trauma continues to intrude
with visual, auditory, and/or other somatic reality on the lives of its victims . . . they relive
the life-threatening experiences they have suffered, reacting in mind and body as though
such events were still occurring” (p. 6).

Traumatic stress, which has the potential to assume “life-threatening proportions”
and is on the extreme end of a continuum of stress (Scaer, 2001, p. 71), is processed
differently. Intense emotional reactions experienced during a traumatic situation may not
connect with one’s cognitive structure and, therefore, not allow for the integration of the
traumatic situation (van der Kolk, 1996). This is relevant with respect to children in that
their concept of the world and their ability to organize new situations is far narrower than
that of adults, thus contributing to the situation whereby their cognitive schemas are more
easily stressed (Gelinas, 2001). The traumatic event, which is somatosensory, motor, or
cognitive, becomes dissociated and reappears when an external trigger stimulates the
memory, which is then experienced as if the trauma is reoccurring (Rothschild, 2000; van
der Kolk). At the time the trauma reoccurs, the images and behavior impulses are not
attached to concepts or understanding. Ogden and Minton (2000) contend that using a
sensory motor approach that enhances body awareness treats the effects of trauma on the
body. The approach also affects the cognitive and emotional processing of the individual.

Siegel addressed the issue by stating that, in the face of traumatic events, the brain
cannot easily adjust to the experience and trauma can “overwhelm affect regulation
mechanisms, and various forms of adaptation may be required to maintain equilibrium”
(1999, p. 294). The emission of stress hormones contributes to toxic effects in the part of
the brain that governs self-regulation (Siegel). Additionally, the meaning one has regarding the trauma has as much relevance as the traumatic situation itself (Scaer, 2001).

Early traumatic events–such as witnessing violent acts, experiencing incest, or undergoing the death of a caregiver–interfere with a child’s ability to manage future traumatic stress. Reactions to traumatic stress vary. Researchers (Perry, 2001a, 2001b; Perry et al, 1996; Scaer, 2001; Siegal, 1999) have found that infants, young children, and females tend to dissociate; this is commonly referred to as the “freeze state” and is an example of hypoarousal. Hypoarousal includes a numbness, a decrease in body awareness, a decrease in movement, a disconnect from emotion or thought, and an inability to assess threatening situations (Ogden & Minton, 2000; Siegal). Adult and adolescent males, on the other hand, tend to become agitated and experience a “fight or flight” response as in hyperarousal, which involves symptoms that overuse available energy and include increased heart rate, rage episodes, irritability, pacing, difficulty falling asleep, and tremendous pounding in the head (Ogden & Minton; Putnam, 1997; Siegel).

The effect of trauma on children and adolescents occurs at the most vulnerable time of one’s life–childhood. Even the act of witnessing violence has adverse effects on children and adolescents (Maughan & Cicchetti, 2002; Perry et al, 1996; Scaer, 2001; Siegel, 1999). When children or adolescents are traumatized, the reactions of the adults in their lives are important. In general, adults tend to interpret the behaviors, language, and life experiences of traumatized children based on their own beliefs. Often, such adult behavior can be unsympathetic to the child. Also, many believe that a child’s “resilience”
will carry and protect the child through the trauma (Perry et al.). Perry (1997), however, believes that children should be described as “malleable” rather than “resilient,” since “malleable” is a more accurate description of what occurs with traumatized children.

When children and adolescents are traumatized, there are recognizable aftereffects (Clark, Lesnick, & Hegedus, 1997). In a review of 10 years of research in the area of child sexual abuse (CSA), Putnam (2003) observed that lifetime rates of depression were three to five times more common in women with childhood sexual abuse histories when compared with women without child sexual abuse histories. He also reported that earlier onsets of depression were indicated in individuals with CSA histories. The aftereffects extended beyond depression. Women who reported being sexually abused as children were diagnosed with extended episodes of unipolar depression (Putnam).

The extent of the aftereffects of extreme abuse is influenced by several factors—whether or not contact sexual abuse was involved (Teicher et al., 2002), the level of physical force (Garnefske & Diekstra, 1997), whether or not there was a close relationship with the perpetrator (Trickett et al.), and the gender of the child (Garnefske & Diekstra). Research indicates that poor long-term outcomes were reported in cases of contact sexual abuse (Trickett et al.) and that boys tended to suffer worse outcomes than girls (Garnefske & Diekstra).

Interested in sexual abuse as it relates to gender differences, Garnefske and Diekstra (1997) studied 1,490 male and female students from the Netherlands. The students ranged in age from 12 to 19 years. One-half of the students, 745, had sexual abuse histories; the other half did not. Girls with sexual abuse histories reported suicidal
ideation or attempted suicide 4.8 times as often as girls who did not have a history of sexual abuse. Boys with sexual abuse histories reported suicidal ideation or attempted suicide 10.8 times as often as boys without a history of sexual abuse. The ratio of suicide related reports for males (10.8:1) was more than twice the ratio reported for girls (4.8:1). Additionally, sexually abused males in the Garnfske and Diekstra study reported more emotional and behavioral problems than did both their non-abused male counterparts and the sexually abused females in the study. Garnfske and Diekstra’s research findings pointed to a strong association between being sexually abused and exhibiting multiple problems for both males and females. Their study also showed a greater frequency of sexual abuse accompanied by physical abuse for males than for females.

In 1997, Clark et al. studied adolescents with alcohol abuse and dependence problems. They found a strong association between alcohol use and a history of trauma in the adolescents. The researchers studied 256 individuals between the ages of 14 and 18. Of these, 73 adolescents were randomly selected and served as the control group. The other teens–132 with alcohol dependence and 51 with alcohol abuse–were in intervention programs. They served as the experimental subjects. Teens with reported alcohol abuse or alcohol dependence were 6 to 12 times more likely to have a physical abuse history and 18 to 21 times more likely to have a sexual abuse history than did teens without reported alcohol-related problems. Clark et al. also found that sexual abuse was more common with females, while other violent acts were more frequently reported by males. Clark and the other researchers called for additional studies in this area so as to understand the “development and course of adolescent alcohol abuse and dependence” (p. 8).
Additionally, they recommended a comprehensive clinical assessment of traumatic experiences in those adolescents with alcohol related problems.

In other research (Glod, Teicher, Hartman, & Harakal, 1997), the sleep patterns of 19 prepubertal abused children, 15 non-abused children, and 10 depressed children were studied. Several findings resulted from the study: (a) the abused children were twice as active while they slept as the non-abused and depressed children; (b) those children who had been physically abused showed more sleep problems than the sexually abused children; (c) abuse affected sleep patterns even though the child may not have met PTSD criteria; and (d) children reporting depression did not exhibit signs of sleep deprivation. The researchers recommended that abused children be assessed for sleep disturbances and that further research focus on the effects of maltreatment on sleep patterns. They suggested this research could lead to the development of effective treatment interventions.

Neglect is the most common form of child maltreatment in the United States, and, yet, it is the least researched (Schumacher, Smith Slep, & Heyman, 2001). It comprised 54% of the documented abuse cases in the United States in the year 1997. Neglect involves the failure of a caregiver to provide necessary care to a child resulting in harm to the child. Necessary care includes provision for age-appropriate levels of supervision, education, medical care, and basic life necessities–food, shelter, and clothing (Schumacher et al.).
Attachment Theory

The Foundations of the Relationship

Attachment is the “bond that forms between the infant and mother” (Schore, 2001, p. 6) and “the foundation from which the mind develops” (Siegel, 1999, p. 68).

Attachment is formed by the repeated interaction between an infant and a maternal caregiver, fostering a connection between them during the first year of life. In addition to facial expressions and voice tones, feelings and emotions are part of the interaction that occurs between the mother and the infant. This mother-infant relationship is fundamentally biologic in nature. It contributes to affect regulation and is the basis of the infant’s coping process, laying the foundation for one’s ability to adapt to stress throughout the life span (Bowlby, 1988; Schore).

The attachment relationship, in which the child internalizes the facial expressions, voice tones, and touches of the caregiver, protects the infant from danger and partially provides the foundation for the development of the child’s mind as the child learns to regulate high levels of stimulation including affect (Perry et al., 1996; Schore, 1994, 2002; Siegel, 1999). Schore (2001) believes affect regulation is the function of the right hemisphere of the brain, which develops through the attachment relationship.

Since 1980, a number of researchers (Bowlby, 1988; Cicchetti, 1984; Putnam, 1997; Schore, 2001; Siegel, 1999; van der Kolk, 1996) have emphasized that the attachment bond provides a sense of security in the infant. The level of security in the child-caregiver relationship determines how actively the infant will explore the environment (Cicchetti & Rogosch, 1994, 2001). As the infant’s development moves
forward, the characteristics of the relationship are represented internally (Cicchetti & Rogosch, 1994, 2001; Schore). That bond serves as the primary defense against trauma-induced psychopathology.

Specifically, John Bowlby’s (1988) research on attachment theory acknowledged the biological aspect of the infant-maternal or infant-primary caregiver relationship as essential for a human’s survival and “provided a powerful new perspective on the effects of trauma on child development” (Putnam, 1997, pp. 22-23; Schore, 2001). In the process of attachment, the immature brain of the infant responds to the mature adult brain and the adult responds to the signals the child provides (Schore, 1994, 2001; Siegel, 1999).

**The Relationship to Trauma**

Trauma can occur as early as infancy, thus having a direct effect on the attachment process (Schore, 2001). Attachment is believed to be the foundation in understanding the developmental-psychopathological perspective regarding the effects of trauma—abuse, neglect, loss of the mother figure, mental health issues in the caregiver, lack of stimulation—on children (Cicchetti et al., 1995; Putnam, 1996). Bowlby (1988) believed that attachment theory provided an explanation of the way psychopathology evolved and that it provided a foundation for clinical interventions with various mental health disorders (Cicchetti et al.). Originally, Bowlby’s research was recognized in the field of developmental psychology. Recently, however, his research on attachment theory has been acknowledged in light of other research on childhood trauma (Cicchetti et al.).

Mary Ainsworth, a developmental professor who worked with Bowlby, formulated a research protocol in which four classifications of attachments are identified.
The protocol, known as the “Infant Strange Situation,” is a quantifiable instrument measuring the level of security in the attachment relationship (Ainsworth, Blehar, Waters, & Wall, 1978; Siegel, 1999). Prior to the establishment of the protocol, a caregiver-infant relationship was studied in the home for one year. At the end of the year, the mother and infant participated in a 20-minute process in an unfamiliar environment. During that time, the infant spent time with the mother, then with the mother and a stranger, and, finally, with just the stranger. The child was then left alone for a period of time. The child was finally reunited with the mother. Ainsworth believed that this process would activate the attachment relationship. The scenario was evaluated by trained coders who assessed the separation and reunion between the child and the mother. The coders evaluated the child’s response to the reunion with the mother and focused on how the infant sought connection with the mother, how easily the child was soothed, and the speed with which the child returned to playing. It was believed that securely attached infants would be comforted and calmed by the mother and would readily transition into play and that the insecurely attached child would not be soothed by the mother and would not return to play (Ainsworth et al.; Siegel). The results of the laboratory study correlated with the observations recorded from the year-long in-home observations and evaluations. Ainsworth’s “Infant Strange Situation” has been replicated and the research protocol is considered fundamental in researching attachment relationships (Ainsworth et al.; Cicchetti & Rogosch, 1994; James, 1989; Siegel).

Initially, there were three classifications of infant responses; however, as the research proceeded, it was evident that a fourth classification was indicated (Cicchetti,
et al., 1995a; Siegel, 1999). The first three classifications were identified and described by Ainsworth and were designated Type A, Type B, and Type C.

Type A, insecure-avoidant, identifies a child who independently explores the environment before the parent exits and shows limited affect when the parent leaves. On the parent’s return, the child displays active avoidance by looking away, moving away, or ignoring the parent and focusing on the toys provided. Type B, secure-caretaker, identifies a child who is secure when distressed. The child will cry by the second separation and will seek contact when the parent returns. The Type B infant readily explores and shows affection. Type C, insecure-ambivalent, identifies a child who has difficulty separating from the parent in order to explore. The child is anxious of new situations. When the parent returns, the child displays difficulty, may fuss, kick, or hit. The child may also be passive, will not settle, cries, and does not return to the toys provided (Ainsworth, et all, 1978).

Main and Solomon (1986) identified Type D–disorganized-disoriented–for the child who shows simultaneous, contradictory behavior, undirected and incomplete movement, little affect, freezing, a trance expression, and apprehension toward the parent. The child may cling to the parent while crying hard and lean away or may huddle or lay prone on the floor (Cicchetti & Rogosch, 1994, 2001; Main & Solomon; Siegel, 1999). The Type D classification is associated with maltreatment. The infant cannot rely on the parent for comfort since the parent is the source of the maltreatment.

Research on attachment is lacking for two primary reasons. First, its focus is on the child’s first year to 18 months of life; little is known about the manner in which
disrupted attachments affect the adjustment of older children (Kobak, Little, Race, & Acosta, 2001). Second, it focuses on the attachment relationship with the same caregiver over time. It does not address disruptive attachments that are the result of out-of-home placements for children in foster care and those who have been adopted (Kobak et al.).

Disruptions in the Relationship

Attachment disruption is an extensive and unexpected separation from the attachment figure and disrupts the child’s assurance regarding the availability of the attachment figure (Kobak et al., 2001). Because attachment theory generally deals with the first three years of a child’s life, there is little research concerning attachment disruption and its effects after the age of three. Yet, Kobak et al. studied boys aged 10 and 11 who experienced unplanned disruptions of the attachment figure–mother and/or father. None of the disruptions involved divorce. They found that 64% of the socially and emotionally disturbed (SED) group experienced a major disruption or loss of their mother, while 78% of the SED group experienced the loss of their father. The SED group was compared with both a “high risk” group, consisting of boys from low-income families of similar ethnic backgrounds, and a comparison group, which consisted of middle class boys. Neither the high risk nor comparison group boys were identified as SED. Only 25% of the high risk group and 9% of the comparison group experienced unplanned disruptions of the attachment figure. The children in the SED group had Dissociative symptoms. Attention disruptions were linked to dissociative symptoms and distinguished the SED children from their high risk and comparison counterparts in the study.
Often, attachment disruptions result in out-of-home placements. The number of children in the United States in placement cannot be overlooked. In the year 2000, 556,000 children were in foster care. The average child in foster care was 10 years of age and stayed with a foster family for an average of 33 months. Fifty-seven percent of the children in foster care were reunited with their parents after an average of 22.7 months away from home (Child Welfare League, 2003). The effects of these disruptions, complicated by prior traumatic events caused by the removal, have ongoing developmental implications. Both the removal of a child from her/his birth home and a disruptive placement for that child can be traumatic (Kobak et al., 2001; Scannapieco & Jackson, 1996).

Problems in adaptive behavior are recognizable in children removed from their family of origin. Fifty percent of the children in foster care exhibit impaired behavior such as defiance, aggression, self-injury, hyperactivity, and misinterpretation of social queues. Children who previously experienced trauma in the attachment relationship, including abuse, neglect, and attachment disruptions, who were later placed in foster care, tended to develop Dissociative symptoms. In fact, these attachment disruptions contribute to the evolvement of psychopathology (Kobak et al., 2001).

Developmental Psychopathology

Developmental psychopathology, a relatively new field that has developed over the last 30 years (Cicchetti, 1984; Sroufe & Rutter, 1984), is based on development and its associated deviations. Sroufe and Rutter defined developmental psychopathology as the “study of the origins and course of individual patterns of behavioral maladaptation,
whatever the age of onset, whatever the causes, whatever the transformations in behavioral manifestation, and however complex the course of the developmental pattern may be” (p. 18). In other words, developmental psychopathology takes a comprehensive view of the factors, such as child maltreatment and traumatic loss, that contribute to adversity, including an acknowledgment of changes and reorganizations that occur from the development of the self or ontogenesis (Cicchetti & Toth, 1995; Sroufe & Rutter) as well as the environment surrounding the person.

The research in this field promotes the exploration of various domains, over time, regarding risk to individuals and their resilience (Cicchetti, 2002). The domains include functioning and behavioral organization, biologic regulation, affect, cognition, representation, and interpersonal relations. This theoretical approach promotes the concept that human development is a sequential process that adapts “qualitative reorganizations among and within biologic and behavioral systems as growth of the individual proceeds” (Cicchetti & Rogosch, 1994, p. 759). Aspects of the biologic and behavioral psychological environmental and social events occurring within each domain are believed to be an interactive transaction over the life span of the individual.

A dual relationship exists between understanding “normal” human development and understanding psychopathological development; that is, an appreciation of normal development is required in order to understand psychopathology and exploring psychopathological development can enhance one’s knowledge of normal development (Cicchetti, 1984, 2002; Cicchetti & Rogosch, 1994). Developmental psychopathology includes the study of childhood behavior problems and their connections to “normal”
human development (Sroufe & Rutter, 1984). While a discussion of normal human development is beyond the scope of this paper, a brief discussion of psychopathological development is appropriate.

Cicchetti and Rogosch (1994, 2001) believe that several areas provide the conceptual framework for developmental psychopathology. These include embryology, neuroscience, psychiatry, psychoanalytic theory, and psychology. Due to the fact that developmental psychopathology supports “multi-disciplinary, multicultural, and multicontextual” (Cicchetti & Toth, 1995, p. 543) viewpoints, it encourages the integration of differing perspectives.

Developmental psychopathology is very broad in its concerns and investigations. It also deals with the functioning of those children who are not affected by adversity, the resilience that exists in the maltreated population, and the processes that lend themselves to positive outcomes (Cicchetti & Toth, 1995). Researchers in this field investigate those personal characteristics and protective factors in a child’s environment that contribute to the child’s rebounding and functioning without obvious behavior or biologic problems. Researchers in this field explore various domains, over time, regarding risk to individuals and their resilience (Cicchetti, 2002).

Child maltreatment generally leads to developmental problems. Although not all maltreated children have problems in all emotional areas, “problems in any one of these areas would increase the likelihood of the development of psychopathology” (Pollak, Cicchetti, & Klorman, 1998, p. 814; Cicchetti & Toth, 1995). Only in the last decade has the “physiological impact of maltreatment” (Pollak et al., p. 812) received attention from
researchers in the field of neuroscience (Cicchetti, 2002; Cicchetti & Tucher, 1994). The research involves not only the consequences but also the sequelae of child maltreatment and has led to the accumulation of more information regarding the effects of the environment on the brain. This research has also enhanced the clinical field’s understanding of the effects of maltreatment and negative social experiences on brain structure and function and on genetic functioning (Cicchetti; Perry et al., 1996; Schore, 2002).

Putnam (2003) stated that the “nature of the relationship of neurobiological abnormalities with the plethora of symptoms and problematic behaviors associated with CSA (childhood sexual abuse) must be established” (p. 275). This indicates that further research is needed to learn which aspects of brain neurobiology affect specific symptoms and behavior problems for those having histories of childhood sexual abuse as well as other forms of maltreatment.

At each level of development, children are challenged with specific tasks appropriate for that specific level. These tasks encompass affect regulation, attachment with the primary caregiver, a sense of self, establishment of peer relationships, and the ability to adapt to school. Each of these developmental accomplishments depends on the child’s adaptation to the accomplishments of the previous level (Cicchetti & Rogosch, 1994). Traumatic events that occur at one or more of the child’s developmental stages may, in fact, often, lead to a wide and varied range of disruptions which are dependent on the developmental level of the child when the traumatic event occurred (van der Kolk et al., 1996).
**Etiology**

Bronfenbrenner, a developmental psychologist, established an ecological theory of development that emphasizes the interaction of the child and the environment in which the child lives, focusing on how the child perceives her/his environment (Bronfenbrenner, 1979; Thomas, 1996). Because Bronfenbrenner’s work was adapted by developmental psychopathologists (Belsky, 1993; Cicchetti & Toth, 1995), it is important that we review his theory.

Bronfenbrenner theorized that the child is affected by the immediate environment in which he/she lives. The child’s environment, which Bronfenbrenner calls the microsystem, includes the activities, roles, and interpersonal relationships experienced in the home, school, or peer group (Bronfenbrenner, 1979; Thomas, 1996).

The second aspect of Bronfenbrenner’s social ecological theory is referred to as the mesosystem, which is composed of the processes that occur between two or more of the settings in which the child interacts. The focus is on the “synergistic effects created by the interaction of developmentally instigative or inhibitory features and processes present in each setting” (Bronfenbrenner, 1993, p. 22). That is, the “interrelationships among Microsystems can influence the child’s perceptions and behavior within any of the settings in which the child is presently located” (Thomas, 1996, p. 386). For example, a child is impacted by what he/she believes are the attitudes of her/his parents when he/she is in school. The attitudes established in the school setting, in turn, affect the child’s behavior within the home setting.
Bronfenbrenner’s next layer is called the exosystem, which lies beyond the mesosystem and refers to the processes that transact between two or more settings, one of which does not hold the child but in which situations occur that “indirectly influence processes within the immediate setting in which the developing person lives” (Bronfenbrenner, 1993, p. 22). An example of the mesosystem is the following scenario. A seven year old child in a partial hospitalization program reports his greatest trauma was being removed by a caseworker for Children and Youth Services and the local police from his family and placed in a temporary foster home. In this case, the child is affected by federal and state laws that mandate professionals make a CPS (Child Protective Service) report when child abuse or neglect is suspected or reported. The system of federal and state laws serves as the exosystem in this example.

The final aspect of Bronfenbrenner’s theory is the macrosystem. It is the most distant from the child and contains the beliefs, values, practices, and attitudes of the child’s society. It is the “cultural milieu.” The macrosystem surrounds and contains all of the other systems described above. The relationship of the four systems—microsystem, mesosystem, exosystem, and macrosystem—is described pictorially in Figure 1.

Bronfenbrenner emphasized the importance of understanding how a child perceives an event or the environment and reinforced the significance of the relationships that exist between the settings in which the child functions. He stated that child abuse and neglect are determined by many factors (Bronfenbrenner, 1979), primarily interactions between the different systems in the child’s environment. While Bronfenbrenner believes that the way in which a child’s separate settings interconnect has a direct influence on the
child’s development, his theory also includes the notion that development is affected by situations that occur in settings where the child is not present (Bronfenbrenner, 1993; Thomas, 1996).

Bronfenbrenner (1993) continued to develop his theory and added two significant processes that he thought enhanced development: a) the manner in which children interact with others and b) the activities in which children participate. These two processes are further influenced by four attributes children bring to their encounters with other individuals and actions.

First are individual personality factors that either encourage or deter responses from the environment and, subsequently, promote or disrupt the child’s psychological

![Figure 1 Bronfenbrenner’s developmental exosystem, as adapted by Thomas (1996)](image-url)
growth (Bronfenbrenner, 1993; Thomas, 1996). For example, a child’s physical appearance and its importance in an environment is such a factor. Children respond differently to a child who wears designer clothing than they do to a child who wears off-brand or “hand-me-down” clothing.

The second attribute is the child’s interests, and subsequent explorations, in the social environment (Bronfenbrenner, 1993; Thomas, 1996). Some children are inclined toward sports, while others prefer reading or video games.

Third is the degree to which a child is encouraged to seek complex activities or restructure her/his surroundings by more elaborate means (Bronfenbrenner, 1993; Thomas, 1996). For example, the parents could provide toys—building blocks, miniature cars, and human figurines—that allow and encourage the child to set up a town, thus restructuring her/his immediate environment.

The fourth attribute concerns itself with the ability of growing children to arrange their experiences and create ways to implement their ideas in reality. Here children devise and carry out plans (Bronfenbrenner, 1993; Thomas, 1996).

Cicchetti and Rizley, researchers in developmental psychopathology, adapted Bronfenbrenner’s theory and created a model that addressed maltreated children and the long-term transactions that occur between a child and the levels of social ecology which Bronfenbrenner had described (Cicchetti & Rogosch, 1994; Cicchetti & Toth, 1995). Like Bronfenbrenner, they asserted that child abuse and neglect must be viewed with respect to a broad context of factors functioning across systems rather than from a cause-and-effect approach (Cicchetti & Rogosch, 1994; Maughan & Cicchetti, 2002) and cited
environmental forces and the characteristics of both the child and the caregiver as influences of one another (Cicchetti & Rogosch).

The research in developmental psychopathology led to the identification of two types of risk factors—potentiating and compensatory. Potentiating risk factors are those that increase the probability that maltreatment will occur. Examples of potentiating factors include poverty, unemployment, ineffective parenting techniques, domestic violence, and chemical dependency. These types of factors contribute to poor adaptation in neglected and abused children. Compensatory factors decrease the probability of maltreatment. Employment, healthy parenting skills, adequate finances, and positive marital relationships are examples of compensatory characteristics that contribute to positive adaptation in maltreated children. As is obvious from these definitions, maltreatment occurs when potentiating risk factors are greater than compensatory risk factors (Cicchetti & Toth, 1995).

Other factors were identified as being involved in the abuse and neglect of children. The first of these are enduring vulnerability factors. They are long-term factors, conditions, or attributes of the parent, the child, or the environment and may be biological, historical, psychological, and/or sociological in nature. Examples include poverty, domestic violence, and community violence. Enduring protective factors were also identified. These are permanent characteristics that decrease the potential for maltreatment. Examples include a secure marital relationship and a stable employment situation in the home setting (Cicchetti & Toth, 1995; Emery & Laumann-Billings, 1998).
Child abuse and neglect do not exist alone and from this literature review, no single cause of child maltreatment was identified (Belsky, 1993; Bronfenbrenner, 1979; Cicchetti & Toth, 1995; Heineman, 1998; James, 1989). Rather, child abuse and neglect are related to developmental issues as part of a child’s interactions with the social ecology that includes the social environment, community, and culture (Cicchetti & Rogosch, 1994). Each aspect of the environment–family, peers, school, and community–contains characteristics which influence the path of a child’s development. While individual differences affect development, the interactions of family members, childcare providers, teachers, clinicians and others affect the child’s way of adapting. In this transactional model, child abuse and neglect are affected by both risk and protective factors within an ecological framework (Heineman, 1998).

At the present time, research does not provide a thorough explanation as to why some children develop PTSD, other children become anxious or depressed, and yet other children remain resilient to stressors that affect their peers (Davidson, Inslicht, & Baum, 2000). It is obvious that more research must be conducted in this evolving field of study.

Neurodevelopment

Clinical approaches and theoretical orientations need to be coordinated in many disciplines. In understanding the impact of trauma, neurobiology provides a multimodal approach and improves the theoretical construct. Gilles reports that “understanding the influence of biologic systems may explain a significant amount of individual variability in outcomes to child maltreatment” (1999, Integrative Model Development section, ¶ 3; Perry et al., 1996). Perry et al. asserted that at least one-half of all children experiencing
traumatic stress will “develop significant neuropsychiatric symptomatology” (p. 3), particularly those who experience relational trauma such as domestic violence. A multi-disciplinary approach can enhance the research of the aftereffects of trauma on development. Traumatic stress in childhood increases the likelihood of developing neuropsychiatric symptoms by adolescence and adulthood (Perry et al.).

Research (Gilles, 1999; Glaser, 2000; Perry, 2001a, 2001b; Perry et al., 1996; Siegel, 1999) indicates that child abuse and neglect change both brain functioning and brain structure in those areas of the brain that are related to stress response. The brain changes in accordance with an individual’s experiences—both positive and negative—within one’s environment. This process of change is known as brain plasticity (Perry, 1999a, 1999b; Scaer, 2001; Schore, 2002). “It is the brain that mediates all emotional, cognitive, behavioral, social and physiological functioning” (Perry et al., 1996, p. 272).

The most rapid change in human brain development occurs from birth to age three. At birth, the volume of the human brain is approximately one-third developed. By the age of three, the brain has developed to 90% of its mature volume (Perry, 1999a; Schore, 2002). It should be noted that some researchers extend this to age five (Teicher et al., 2002). While functional maturity of the cortex occurs through adulthood, other areas of the brain are fully mature at varying times of development. Neuro pathways continue to change and develop throughout the life span of the individual, depending on her/his life experiences and genetic makeup (Perry, 2001a; Perry et al., 1996; Schore; Teicher et al.).
In utero, the brain of the developing fetus has three times the number of neurons, or nerve cells, of an adult brain. At the time of birth, one-half of those neurons are eliminated by cell death, known as apoptosis, leaving approximately 100 billion neurons. After birth, the brain continues to develop (Perry, 2001a; Perry et al., 1996; Schore, 2002; Teicher et al., 2002). Neurons connect with each other at specialized locations known as synapses. At this intersection, the space between the neurons, known as the synaptic cleft, is small. At the synaptic connection, a chemical known as a neurotransmitter or neurohormone is released from one neuron into the synaptic cleft and is then transmitted to the next neuron. Over time, through this process, neurons are organized into systems that perform various functions such as sense, process, store, perceive, and act on data from the external and internal environment, contributing to the human’s functioning (Perry; Teicher et al.). The frequency with which a neural system is activated the more indelible the internal representation” (Perry et al., p. 4).

The brain is organized in a sequential manner. Each part of the brain has its own developmental timetable, starting with the brainstem, which is less complex than other parts of the brain. The development of three other areas of the brain—the midbrain, the limbic area, and the cortex—follow and depend on the brainstem’s development. Each of these areas of the brain has a “sensitive time” of development during which the neurons and their systems are organizing and are greatly affected by the human’s experiences and genetic makeup. The development of each area of the brain depends on the previous development of another area (Perry, 2001a; Siegel, 1999; Schore, 2002).
The brainstem develops in utero and is fully operational at birth; therefore, it is most sensitive prenatally. Without the brainstem, the infant would die since it is responsible for heart rate, temperature, pulse, and respiration (Perry, 2001a; Siegel, 1999; Schore, 2002). The midbrain, also known as the diencephalon, develops rapidly during infancy and matures during childhood. It regulates primary and secondary motor control. In some literature (Levine, 1997; Scaer, 2001), the brainstem and the diencephalon are known together as the “reptilian brain.” The limbic area of the brain develops actively during early childhood and reaches its mature state during puberty. The limbic area contains the memory systems and plays a key role in attachment, emotional and affect regulation, and primary sensory integration. It compliments the brainstem. The cortex actively develops during childhood and is functionally mature in adulthood. The area of highest processing in the brain, the cortex is also the most plastic and governs reasoning, problem solving, abstract thinking, and secondary sensory processing (Perry, 2000a).

The developing brain organizes and internalizes new data in a use-dependent manner (Perry et al., 1996) which means that experience stimulates specific paths in the brain that intensify what is already in place and creates new development (Siegel, 1999). An example of this is the development of language. In healthy infant familial relationships, infants are verbally engaged with sounds and words. As the infant matures, he/she learns by repeating. Because experience is the foundation for neurodevelopment, the brain of an infant or child is more sensitive to experience than is the brain of a mature adult (Perry, 2000). Even in adolescence, brain changes are experience-driven rather then
gene-driven (Perry, 2001a). Once an area of the brain is mature, it is less likely to be affected by experience (Perry, 2000).

Trauma, including abuse and neglect, is an example of the many environmental factors that can contribute to a negative effect on a child’s development and brain functioning (Cicchetti & Rogosch, 1994, 2001; Glaser, 2000; Perry et al., 1996). In a sample of hospitalized children with abuse histories confirmed by the Department of Social Services, 72% of the children had significant EEG abnormalities in the frontotemporal lobes. These abnormalities were caused by “alterations within the left hemisphere” of the brain (Teicher et al., 2002, p. 404). In this sample, an association between the abnormalities and histories of violent and self-injuring behavior were found. Additionally, Teicher et al. (2002) and De Bellis et al. (1999), in two separate studies, found that the middle section of the corpus callosum, a connector between the left and right brain hemispheres, was smaller in maltreated–abused or neglected–boys with psychiatric inpatient histories when compared to a control group. De Bellis et al. showed that the small size of the middle section of the corpus callosum stood out as the single most anatomic finding observed in abused children and in those with PTSD. In the female population, this condition was evident with those who were sexually abused (De Bellis et al.; Teicher et al.). This reduced size of the corpus callosum is related to a decrease in the communication between the right and left hemispheres. The research of Teicher et al. indicated that early maltreatment is associated with an increase in laterality of the hemisphere with a reduction in the integration between the hemispheres.
After a traumatic situation, children typically experience a behavioral, cognitive, or emotional disruption connected to the changes in the neural systems of the reptilian brain. The greater the activated stress response related to the severity, intensity and frequency of the trauma or traumas, the greater the probability for a use-dependent change in the neural systems (Perry, 2001a, 2001b; Perry et al., 1996). The neural systems that operate in the stress response will develop in a way that functions as if the human is in a state of constant threat. When the symptoms are severe and disruptive, they develop into a clinical disorder and, as such, even when there is no true threat, the brain responds as if the initial trauma is being experienced. A once protective functional response evolves into a maladaptive function (Perry, 2001a).

Children living in a chaotic and violent environment in which they are exposed to repeated traumatic stress necessitates the stress response in the brain to be consistently active, thus contributing to the neural systems organizing so as to adapt to this environment for the purpose of survival (Perry, 2001a). As a result, the functions that neural systems regulate—the sympathetic-parasympathetic tone, intensity of vigilance, mood regulation, attention, and sleep patterns—become poorly regulated, overactive, and hypersensitive. Under these conditions, affected children respond in an adaptive manner and become hypervigilant, reactive, impulsive, and overly sensitive. Complicated by distortions in thinking and misinterpretations of cues in social situations, these children become accustomed to living with low levels of fear (Perry).

Perry’s (2001a, 2002) research at the Child Trauma Clinic in Baylor, Texas involving 108 traumatized children led to a conclusion relating to measures of
intelligence. When IQ (intelligence quotient) scores were measured using the WISC (Wechsler Intelligence Scales for Children), a significant difference in the verbal (8.2) and performance (10.4) scores occurred. Although many of the children were identified as learning disabled in their schools, their teachers identified them as being “smart” but unable to learn easily. Perry contends that these children arrive at school with their nervous systems in a chronic state of arousal or perhaps in a dissociated state. They, certainly, are not focused on learning because the processing portions of the brain and cortex are shut down (Perry). In order to process new information and learn, the child’s cortex needs to be “up”; that is, the child needs to be relatively calm. This is not the case for many of these traumatized children who could have experienced a night and/or morning of violence and chaos. The limbic systems in these children are activated, and the children process the nonverbal behaviors of those around them, such as the facial expressions and movements of the teacher or other adults. For example, one of the children who participated in the trauma groups put it this way: “When my stepdad has a red face and red eyes, I know to hide under my bed. When my teacher has to yell at someone, her face gets a little red, I want to hide under my bed ‘cause I don’t want bad things to happen.” Perry found that these children also experience test anxiety. Although they “knew” the information being tested, when in a state of anxiety and panic at the time of the test, that portion of the brain in which the needed information is stored shuts down. The information is not available. Additionally, he found that these states of arousal or hypoarousal create problems socially and emotionally, causing affected children to
misinterpret social and non-verbal cues out of context. Perry stated that “the cognition and behavior of the child reflect their state of arousal” (2002, p. 6).

Children develop a generalized physiological hyper-reactivity and hypersensitivity to all cues that activate the stress response (Perry, 2001a). This can be observed in children diagnosed with ADHD who have increased muscle tone, increased startle response, sleep disturbances, affect dysregulation, and anxiety. Childhood trauma can also manifest in physical difficulties. Perry’s studies (Perry, 2001a; Perry et al., 1996) found evidence of abnormal cardiovascular regulation and Teicher et al. (2002) identified Type II diabetes in children suffering from trauma.

Risk Factors

Poverty

Because of the nature of this research study, the focus of this section will be on risk factors associated with children living in impoverished rural areas. The influence and effects of poverty on development will also be examined. Reflecting on the previous discussion of Bronfenbrenner’s (1979, 1993) ecological theory of development, it follows that poverty at various levels can influence the development of children (McLoyd, 1998). While Bronfenbrenner’s theory emphasizes the effects of the environment—culture, community, neighborhood, and family—on children, each of these environmental factors can also serve as either potentiating or compensatory risk factors when one reflects on the effects of poverty. In addition to poverty, other factors—gender, race, family structure, substance abuse history, single parent families—have an effect on the developing child (Seccombe, 2000).
Poverty Statistics

Poverty in the context of this discussion refers to income poverty, a “condition of not having enough income to meet basic needs for food, clothing, and shelter” (Brooks-Gunn & Duncan, 1997, p. 55). As difficult as it is to believe, the poverty rate for children in the United States is higher than in most Western industrialized countries (McLoyd, 1998; National Center for Children in Poverty [NCCP], 2002; Seccombe, 2000). According to the U.S. Census Bureau (Proctor & Dalaker, 2003), 10.4% of all families and 16.7% of all children under the age of 18 lived in poverty in 2002, an increase over the previous year. The greatest number of children living in poverty in the United States spend their childhoods in a family headed by a single parent (most likely a young female) who is unemployed, has attained a low level of education, and has a low earning potential (Brooks-Gunn & Duncan). Other factors that correlate with children living in poverty include residing with disabled parents; living in rural areas, particularly in the southern section of the United States (Lewit, Terman, & Behrman, 1997); and living in areas with stagnated economic conditions (Corcoran & Chaudry, 1997). Not surprisingly, childhood poverty has been reduced by factors including smaller families, increased parental schooling, and increases in the number of families with two incomes (Corcoran & Chaudry).

While the statistics for Pennsylvania are not the worst in the nation, they are, nonetheless, alarming. Of Pennsylvania’s 67 counties, 33 are classified as rural counties. Fayette County, the site of this research, is one of the rural counties in Pennsylvania. Because it is important to understand the living conditions of the children in Fayette
County, a brief summary follows which compares conditions in the county with other relevant sections of the state.

Based on data reported by Pennsylvania Partnerships for Children [PPC] (2001) and collected from credible sources including the 2000 United States census report and the Pennsylvania Department of Health, 29.8% of the children under the age of 18 living in Fayette County were identified as living in poverty. This figure was higher than the numbers reported for the same population (children under the age of 18) in all rural counties (18.1%), all urban counties (15.5%), and for all 67 counties (16.6%). In fact, no rural county had a reported percentage greater than that reported for Fayette County (Center for Rural Pennsylvania, 2003).

Because many of the children in the United States who are identified as living in poverty conditions reside in single parent households, it is important to report associated statistics for Fayette County. A greater number of families, 24%, were designated as single female head of household families (PPC, 2001), compared to 17% in all rural counties, 26.9% in urban counties, and 22.6% statewide. Yet, the number of children living in poverty in families with single males as heads of the households was 7.5% in Fayette County. Similar number for all rural Pennsylvania counties was 7.3% , 6.4% for urban counties, and 6.6% for all counties (PPC).

Alarmingly, 13.4% of all Fayette County babies were born to single mothers under the age of 20, the highest rate in the state for all rural counties (PPC, 2001). The average for all rural counties was 8.6%. A larger number of children in Fayette County, 20.8%, were born to mothers with less than a high school education, compared to 16.7%
for all rural counties and 15.1% for all counties (PPC). Additionally, Fayette County had the highest rate of children enrolled in Medicaid, 41.5% compared to 22.8% for all rural counties and 23.2% statewide (PPC). Overall, the story for children in Fayette County is not an encouraging one.

In considering socioeconomic advantage, it is important to consider the length of time a child lives in a poverty situation, whether it is temporary or long-term, and the child’s developmental level while living in poverty (Brooks-Gunn & Duncan, 1997). It is estimated that, at any given time, 60% of all poor children are white, yet almost 90% of those who are poor for more than 5 years were African-American (Corcoran & Chaudry, 1997; McLoyd, 1998). In Fayette County, 92.6% of the children living in poverty in 2000 were white, 4.9% were African-American, 0.6% were Hispanic or Latino, and 0.7% were Asian. Statewide, in all rural counties during the same year, 95.1% of the children were white, 2.1% were African-American, 2.2% were Hispanic or Latino, and 1.4% were Asian (PPC, 2001).

The Effects of Poverty

Although the majority of children designated as living in poverty in the United States are found in rural areas, Evans and English (2002) reported that the bulk of the research on children living in poverty has concentrated on non-White children and youth living in inner cities. Therefore, much of the information has been extrapolated to include children living in rural areas.

Research studies have concluded that children living in poverty situations are exposed to “cumulative, adverse, physical and social stressors” (Evans & English, 2002,
p. 1243). When children of low income were compared with their middle-income counterparts, it was found that their homes tended to be noisier, of lower quality, and more crowded. Additionally, there were physical and psycho-social risk factors that resulted from living in economically disadvantages environments (Brooks-Gunn & Duncan, 1997; Evans & English; McLoyd, 1998). Family income can “substantially influence child and adolescent well-being” (Brooks-Gunn & Duncan, p. 67), and low family income has a greater negative effect when it occurs during the preschool and early schools years (Brooks-Gunn & Duncan).

*Health problems.* Poor children are more likely to have health problems than children not labeled as poor. These health problems include low birth weight, infant mortality, stunted growth (low height for age), lead poisoning, hearing loss, impaired blood production (Brooks-Gunn & Duncan, 1997), prematurity, respiratory and neurological difficulties, cerebral palsy, seizure disorders, visual and motor coordination (Kendall-Tackett, 2002; McLoyd, 1998), and elevated cardiovascular activity including high levels of blood pressure (Evans & English, 2002; Kendall-Tackett).

*Cognitive ability.* Poor children are also identified with learning disabilities, lower levels of intelligence, lower mathematics and reading achievement scores, and developmental delays (Brooks-Gunn & Duncan, 1997). The length of time spent in a poverty situation and the age during which the child lives in poverty have an effect on the cognitive development of children. McLoyd (1998) reported that persistent poverty conditions are more likely to have adverse effects on the cognitive development of preschool children.
School achievement. The effects of poverty on school achievement, while statistically significant, are smaller than other effects (Brooks-Gunn & Duncan, 1997). Yet, children living in poverty situations perform less well on tests than do their non-poor counterparts. They repeat grades more often and are placed in special education classes than non-poor children. Living in poverty also adversely affects high school graduation and high school dropout rates (McLoyd, 1998).

Emotional and behavioral issues. Emotional outcomes such as acting out, aggression, fighting, hyperactivity, and peer conflict have been classified as externalizing behaviors, while emotional outcomes such as anxiety, depression, and social withdrawal have been classified as internalizing behaviors. Children in short-term poverty situations (from one to four years) were associated with more behavior problems. However, the effects were not as large as those associated with children in persistent poverty situations (five or more years). Children in persistent poverty situations are generally identified with internalizing behaviors, and those in short-term poverty situations are associated with externalizing problems.

Psycho-social stressors. Poor children also experience greater family turmoil, child-family separation, and incidences of violence than do their non-poor counterparts. Their homes are more crowded, much noisier, and of a lower quality than those of non-poverty children. Children in poverty situations also experience higher rates of psychological distress. When compared with children from middle-income families, rural children from families identified as living in poverty had more difficulties with
self-regulatory behavior and were less able to delay gratification (Evans & English, 2002).

**Brain Development**

Poor children “face a greater risk of impaired brain development due to their exposure to a number of risk factors associated with poverty” (NCPP, 1999, p. 1). Recent studies of brain development have identified a window during which optimal brain development occurs—from the prenatal period to the child’s first few years. Several risk factors that adversely affect brain development have also been identified. They include inadequate nutrition, substance abuse by the mother, maternal depression, exposure to environmental toxins, trauma/abuse, and quality of day care.

Inadequate nutrition can lead to social withdrawal and delayed motor skills development and physical growth. Substance abuse, including nicotine, alcohol, and drugs, by the mother during and after pregnancy causes “stunted neurons in the brain and a lack of brain cells in crucial developmental stages causing serious neurological disorders” (NCPP, 1999, p. 2).

Since children must be stimulated by their mothers, depression in mothers leads to babies who are “more withdrawn, less active, and have shorter attention spans” (NCPP, 1999, p. 2). Exposure to neurotoxins such as lead “causes brain damage and stunts the growth of the brain” (p. 2) Trauma or abuse result in “extreme anxiety, depression, and/or the inability to form healthy attachments” (p. 2) and leads to violence in later years. Poor day care “hinders a child’s brain activity and impedes development by discouraging interaction and limiting environmental stimulation” (p. 3).
The National Center of Children in Poverty (1999) addresses various ways in which poverty affects brain development. Factors associated with poverty include nutrition, substance abuse, maternal depression, environmental toxins, trauma/abuse and daily care. The developing brain is most vulnerable during the first three years (Perry, 2001a; Perry et al., 1996; Teicher et al., 2002).

Nutrition is an issue when health outcomes are considered since poor nutritional intake is related to health problems including inadequate nutrient adsorption and limited protection against infection (Bradley & Corwyn, 2002). Additionally, inadequate nutritional intake impacts brain development both prenatal and postnatal (Bradley & Corwyn). Inadequate nutritional levels compromise the energy levels of parents and children which, in turn, affects parental response. Growth of the child is affected as well in the quality of the attachment that develops between the child and parent and in the area of negative affect within family interactions (Bradley & Corwyn). Additionally, access to medical care is also compromised. This can affect prenatal care, causing low birth weight and prematurity. Poor children are often taken to emergency rooms for treatment after the medical problem is in more advanced stages because inadequate medical care is prevalent. Often, poor children lack immunizations. This raises the question of the source of the problem—lack of access to resources, poor nutritional intake, or both.

In a study of rural poverty, Evans and English (2002) reported results that included exposure to greater variety of negative physical and psychosocial conditions in children identified as living in poverty than in children living in middle class rural homes. They found that some of the socio-emotional consequences of rural poverty could be
“mediated by cumulative, multiple-stressor exposure” (p. 1245). Impoverished children are “exposed to more extreme environmental conditions that have an influence on development” (McLoyd, 1998, p. 189).

Interventions

Working with traumatized children requires therapists to be creative as they implement the skills needed to help their young clients in the recovery process. Therapists must also possess a substantial understanding of the effects of traumatic stress, particularly with children. While much research currently exists concerning the effects of trauma on children, specific effective interventions are not as plentiful in the literature. For example, there is little information regarding the benefits of individual versus group therapy for children (American Academy of Child and Adolescent Psychiatry, 1998), and far more information exists on the outcome of adult versus childhood trauma interventions (Steele & Raider, 2001). Some of the interventions reviewed in the literature, while interesting, are not relevant when considered in the context of the research being reported in this paper and, therefore, are not included.

Review of Existing Trauma Curricula

Interventions Reviewed in a National Project

Because child abuse is a “crime that frequently results in serious mental health problems for victims, . . . occurs behind closed doors and frequently has little physical evidence, . . . requires the cooperation and often the testimony of the victim for successful prosecution, . . . [and] helping child abuse victims receive the mental health treatment they need is an important component of victim advocacy” (Saunders, Berliner, & Hanson, 2001).
2002, p. 5), the Office for Victims of Crime of the U.S. Department of Justice initiated a collaborative project to address child abuse. Working with the National Crime Victims Research and Treatment Center, located at the Medical Center of South Carolina, and the Center for Sexual Assault and Traumatic Stress, located at the Harborview Medical Center at the University of Washington, mental health assessment and treatment guidelines for child victims of maltreatment and their families were organized and developed.

There were four primary goals of this project: a) to develop specific criteria that could be used by clients, practitioners, agencies, and other concerned parties to judge the appropriateness and efficacy of treatment procedures and protocols often used with abused children and their families; b) to describe the important characteristics of those treatment procedures and protocols in such a way to be easily accessible by professionals; c) to classify commonly used treatment procedures and protocols in several areas--level of theoretical soundness, quantity of empirical support for their therapeutic effectiveness and efficacy, degree of clinical applicability, acceptance by practitioners, and potential for harm; and d) to develop a set of guidelines that could be used in the clinical assessment and mental health treatment of physically and sexually abused children and their families (Saunders et al., 2002). They reviewed and provided brief synopses of treatment approaches in three categories: a) Child-Focused Interventions; b) Family, Parent-Child, and Parent-Focused Interventions; and c) Offender-Focused Interventions.

Twenty-four interventions--nine focusing on only the child; 13 addressing family, parent-child, and parent-focused interventions; and two interventions that were
offender-focused—were reviewed. Each intervention was rated on a scale of 1 to 6, where a score of 1 = “well-supported, efficacious treatment;” 2 = “supported and probably efficacious treatment;” 3 = “supported and acceptable treatment;” 4 = “promising and acceptable treatment;” 5 = “innovative or novel treatment;” and 6 = “concerning treatment,” that is, a treatment that includes a risk of harm, limited supporting research, and possible misapplication of psychological principles (Saunders, et al. 2002, p. 20). Only those interventions applicable to children and the approach taken in the research project reported in this paper are included below.

*Cognitive Processing Therapy (CPT).* Cognitive Processing Therapy (CPT), a preferred intervention for children diagnosed with traumatic stress, is brief in duration and structured in its approach (Resick & Clum, 2002). This therapy is intended to help the victim a) understand how one’s thoughts, emotions, and reactions are related, b) acknowledge that the trauma occurred and must be managed, c) experience the various emotions associated with the trauma, d) examine and challenge maladaptive beliefs (cognitive errors), and e) explore how one’s past, belief system, and world view affect the trauma reaction and, in turn, how the trauma modifies each of these areas.

While one goal of CBT is exposure to the traumatic memory, helping to activate one’s fears and anxieties, exposure alone does not address one’s maladaptive beliefs (cognitive errors/fallacies in the belief system). Once the cognitive component is included, the child is provided with a means to understand and identify the experience, thus assisting the child in processing overwhelming emotions. New information does not always fit with one’s existing schemas. In the case of a traumatized child, confusion and
strong emotions are not processed. CBT helps clients use accommodation in processing new information (Resick & Clum, 2002).

This approach makes substantial use of writing by the traumatized child. Children in this therapy program are required to handwrite impact statements at both the beginning and end of the therapy program and also complete worksheets1 (Resick & Clum, 2002).

*Trauma-focused CBT.* When used in treating children, trauma-focused CBT centers on the child’s emotional associations with reminders of the traumas; their distorted thoughts about the traumas; and critical thoughts about themselves, others, and their world view. Similar to CBT, trauma-based CBT includes both exposure and cognitive processing. The exposure component addresses the child’s learned fear reactions to thoughts about the trauma (Cohen & Deblinger, 2002). In many instances, for example, children and adolescents believe they could have done something to prevent the trauma or, even worse, that they caused the traumatic event (Kerig, Fedorowicz, Brown, & Warren, 2000; Putnam, 1997; Terr, 1991).

Because this treatment focuses on decreasing negative emotional and behavioral reactions in children and changing dysfunctional beliefs and characteristics connected to the traumatic events. It adheres to the belief that symptoms develop and are maintained by conditioned and learned behavior responses along with maladaptive cognition, trauma-focused CBT therapy reinforces the separateness of thoughts, behaviors, feelings, and physiological responses. Interventions intended to focus on one of these areas

1 Since many of the children in the research study being reported in this dissertation had profound reading and writing problems, this approach, although rated 3, could not be used by the researcher.
contribute to secondary changes in the remaining areas. Clients are informed of the reasons for using CBT in order that they can apply what they learned at home or in other environments (Cohen & Deblinger, 2002).

This treatment approach has been “proven effective for children exposed to a variety of traumatic events and has received the strongest empirical support from studies with abused children” (Cohen & Deblinger, 2002, p. 49; American Academy of Child and Adolescent Psychiatry, 1998; Cohen, Perel, DeBellis, Friedman, & Putnam, 2002). It is used in individual, family, and group therapy in both agencies and schools. It is reported that it requires 12-16 sessions and was rated a 1 in the guidelines (Cohen & Deblinger). However Cohen, Perel, DeBellis, Friedman, & Putnam also state that “it is possible the CBT may be unable to overcome the effect of severe brain function and thus may be ineffective for some children with extreme neurobiological abnormalities.”

**Trauma-focused Play Therapy.** Trauma-focused Play Therapy utilizes play as a method for traumatized children to use toys to externally exhibit the internal representations of their trauma, project thoughts and feelings, and process distressing emotional and cognitive constructs from a place of safety (Gil, 2002). Therapeutic play uses a medium for expression that is natural in a child. It is a structured intervention where the therapist provides toys that encourage the child to recreate or symbolize aspects of the trauma, including thoughts and feelings, so that the child can process the traumatic event. Using play therapy causes the re-exposure of the trauma in a gradual way. The child exposes her/himself to the scenario, story, or behavior they fear, misunderstand, or wish to avoid. Through this reconstruction, the child is able to maintain and manage
overwhelming affect and cognition. In trauma-focused play therapy, the therapist “witnesses the child’s reality, provides unconditional acceptance of the child’s feelings, thoughts, and reactions, challenges cognitive distortions and promotes empowerment and resiliency” (Gil, p. 54). This therapeutic treatment, which usually lasts for several months depending on the needs of the child, was given a rating of 4.

*Eye Movement Desensitization and Reprocessing (EMDR)*. Eye Movement Desensitization and Reprocessing (EMDR), developed by Francine Shapiro in 1989, is a multi-component treatment process for trauma and PTSD. It facilitates the unblocking of traumatic memory that is stored, stuck, or wedged in neuropathways. It encourages changes in thoughts centered on traumatic events and instills positive cognition, coping skills, and adaptive behaviors (Chemtob, 2002). Shapiro uses an information processing model for resolving intrusive traumatic memories that have not been incorporated into the memory system but, instead, float around and erupt in the form of flashbacks, remaining connected to the rest of one’s life experiences (Chemtob). EMDR uses an eight stage treatment process with an emphasis on dual attention stimulus (DAS), formerly referred to as bilateral stimulation. This includes an alternating right and left stimulation (by tapping hands or knees), audio stimulation, or eye movement patterns guided by a trained EMDR therapist. EMDR treatment focuses on the concept that individuals have an internal healing process that is embedded in ones belief system. While this therapeutic treatment was rated a 3 in the referenced guidelines (Chemtob), efficacious treatment outcomes have been substantiated in other sources. Although there are unanswered questions regarding the manner in which EMDR works, adults diagnosed with PTSD
improved (Greenwald, 1997; Perry, 2002; Scaer, 2001; Shapiro, 1995; Tinker & Wilson, 1999; van der Kolk, 1996). Research efforts with children also showed positive outcomes, particularly in the amelioration of memory-related, through the use of EMDR (Chemtob; Greenwald; Tinker & Wilson).

In a well-known intervention, EMDR was used in Mexico with children affected by a hurricane (Crisis mental health clinicians working with child survivors of natural disasters, n.d.). The intervention was later used with children in Columbia and Nicaragua who were also affected by natural disasters (Crisis mental health clinicians working with child survivors of natural disasters). A team of clinicians organized by Dr. Ignacio Jarero provided services to these children. One of the members of the team, Luch Artigas, developed an EMDR protocol known as “Butterfly Hugs.” Used in treating children in groups, the exercise is performed as follows: the child crosses her/his arms (right hand to left shoulder and left hand to right shoulder) over the chest and alternately taps the shoulders at a slow to moderate pace, applying gentle pressure, while imaging pleasant thoughts or a safe place (Cloyd, 2000; Mexican Association for Crisis Therapy, n.d.). It was found that using the Butterfly Hugs in group therapy sessions with the therapist was a “self-soothing experience” for many of the children, probably because they were “directly producing the bilateral stimulation” (Cloyd, ¶ 6). The children were instructed to use this method between sessions, when a disturbing situation occurred, and as an aid to falling asleep.
Other Relevant Interventions

Sensory Intervention for Children, Adolescents, and Parents (SITCAP). Steele and Raider (2001) began to develop their curricula in 1990 at the Institute for Trauma and Loss in Children located in Detroit, Michigan. They created a structured curriculum known as the Sensory Intervention for Children, Adolescents, and Parents (SITCAP) that was designed for children aged 5 to 18, inclusive. SITCAP can be implemented in schools or agencies. Currently, the curricula contains three approaches—exposure, trauma narrative, and cognitive reframing. While it requires between two and eight sessions for parents or caregivers of the children involved in the trauma groups, the exact number of sessions depends on the needs of the caregivers (Steele & Raider). Eight sessions are required for both child and adolescent victims of trauma; due to short attention spans, preschoolers participate in 10 sessions, each 15 to 25 minutes in length.

Steele and Raider view trauma as a sensory experience and identify 10 sensations, or themes, connected to a trauma reaction—fear, terror, worry, hurt, anger, revenge, accountability, safety, power, and shifting victim thinking to survivor thinking. The group sessions for both the children and their caregivers address each of these sensations and concentrate on changing the sensations without focusing on specific behaviors. The authors contend one must “help the victim with the sensations of trauma and behavior will change accordingly” (p. 65).

Exposure intervention entails the reliving of the experience in order to reduce the intensity of the trauma symptoms. Exposure techniques are intended to show the child or adolescent that conditioned reactions are no longer dangerous and that avoiding
reminders of the trauma is no longer required. An important aspect of healing is learning to manage the fears and emotionality one experiences.

The trauma narrative allows the child to tell the story and the therapist, known in this model as the intervenor, to become a witness to the trauma. The intervenor is trained to be inquisitive, ask questions of the child, and respond concretely and literally to the child, and not process or interpret (Steele & Raider, 2001).

Cognitive reframing is essential in this model and reinforces the importance of changing the victim stance to that of a survivor. It includes empowering the child in making choices throughout the healing process that can be transposed to the child’s life style when treatment ends.

Within this curriculum, drawing is a major activity. Because the philosophical basis of this intervention identifies trauma as sensory and drawing is a psychomotor movement that, if focused on the trauma, can trigger sensory memories (taste, touch, sense, vision, sound), drawing is an action activity that allows other aspects of the trauma to be expressed, especially when there have been minimal words spoken. This condition is not unusual in children in that the amygdala, which regulates declarative memory, shuts down and contributes to the child’s lack of verbal capacity. The hippocampus processes the trauma as sensations and drawing triggers the sensory memory in the hippocampus. The child then draws objects that represent the sensory reaction to the trauma. This, then, allows the child to tell the picture’s story (van der Kolk, 1996).

*Group Treatment for Sexually Abused Children.* Group Treatment for Sexually Abused Children was created by Mandell and Damon (1989) from the San Fernando
Valley Child Guidance Clinic in California. They believed that a structured and direct group format for latency age, 7-13, sexually abused children would help reduce the intensity of the trauma, promote self-confidence, instruct age appropriate defenses, and teach respectful peer relationships. This curriculum also includes a group for non-offending parents and caregivers.

Operated under a closed group format, this program continues for 10 months and includes 90-minute weekly sessions with a break for a snack. Playtime is provided at the end of each session. The authors recommend eight same sex participants per group with two same sex therapists as the preferred design. They also recommend that children diagnosed with ADHD be excluded from the program. The curriculum includes 10 modules with handouts, thus requiring the participants to read and write.

Expressive arts. Expressive arts are an additional aspect of trauma therapy that encourage creativity through drawing, music, movement, or journaling. These media allow for the nonverbal expression of feelings and thoughts and provide a way for the child to address overwhelming feelings in a structured manner (Marold, 1998).

Trauma-focused drawing involves the creation of icons or unconscious symbols of the trauma by the child. By asking open-ended questions, the therapist helps the child narrate an aspect of the trauma. Thus, trauma-focused drawing is a creative movement that accesses traumatic memories and provides a pathway for the child to relate her/his story and serves as a step forward toward transforming the trauma into a narrative (Cohen, Barnes, & Rankin, 1995). Cohen, Barnes, and Rankin put it this way:
Art uses visual thinking—the language of lines, shapes, forms, textures, and colors—to create metaphorical images that represent or symbolize ideas and objects. The creative art process uses visual metaphors and visual thinking to move through roadblocks, resolve crises, and transform internal conflict. Visual metaphors are images that stand for ideas, feelings, experiences, objects, sensations, or actions. (p. xvii)

Drawing and art used in trauma therapy are “undoubtedly experiences that can contain unspeakable pain and troublesome feelings, but they are also activities that bring pleasure and a measure of safety and can reveal children’s potentials to adapt, cope, and thrive in what may seem to be overwhelming circumstances” (Malchiodi, 1998, p. 160). Expressive arts allow children to communicate in a positive way and create alternate world views.

Multi-domain Clinical Issues

Experts in the development and implementation of trauma therapy interventions (Cohen & Mannarino, 2002; James, 1994; Rossman & Ho, 2000; Rothschild, 2000) agree that three elements—safety and structure; containment; and empowerment—must be present when doing trauma work. While these three issues may not be directly addressed in each of the above discussed interventions, they are implied in each.

Safety and structure. Safety, in this sense, refers to both physical and emotional safety and is the first goal in managing trauma work (Herman, 1997). Since children are all different with varying degrees of trust, reinforcing the sense of safety through the physical environment, the presence and attitude of the therapist, and the degree of
confidentiality requires as many sessions as a child may need (Herman; James, 1994; Rothschild, 2000). Regardless of age, the client must identify and establish a visual image of a safe or “happy” place. When experiencing intense affect and high anxiety, the client is instructed to refer to the image of the safe place as a way to lessen the intensity of the affect or anxiety. The client’s realization that the physical environment in which the therapy is conducted is a safe location free from trauma can contribute to her/his recognition of the trauma as an event of the past. This is important since addressing the trauma can cause re-experiencing of the event in the present, leading to a re-traumatizing situation such as a flashback (Rothschild). The safe image, which could include a beach, the woods, someone’s front porch, a lake, or a special occasion, can be drawn or a picture from a magazine can be used to reinforce the concept. When the client experiences intense anxiety, affect, or has self-destructive thoughts or urges, this image can be accessed internally as a way to self regulate, decrease the intensity, recapture a sense of groundedness, and develop empowerment.

**Containment.** Containment refers to the ability to manage the overwhelming feelings. This involves keeping the affect stored in an imaged location created by the client. By placing the traumatic material–flashback or sensation–in this pre-created imaged location, the client is able to explore the trauma at a future time without causing overwhelming anxiety in the present. Containment stops the traumatic material from “exploding” into overt outbursts or turning into an abreaction, that is, a visceral reliving of the trauma (Cohen et al., 1995).
Reducing the level of anxiety is an important component in working therapeutically with traumatized children. While anxiety impacts functioning, learning to master self-regulating skills provides a means by which the child controls the sensations he/she is feeling and contributes to self-confidence and self-esteem in the child (Kerig et al., 2000). Relaxation exercises including deep breathing and imagery, have proven to lower blood pressure and heart rates in adults. It is believed that relaxation skills could be helpful for children (Cohen et al., 2002) so that they learn to calm themselves, thereby regulating affect and managing symptoms of hyperarousal. It is also known that meditation assists in reducing the effects of stress, especially with individuals with many somatic problems and assists in healing the immune system (Cohen et al.).

For some clients, relaxation can create more anxiety. In that case, teaching muscle tension is a consideration. This exploration or realization demands body awareness, determining where in the body the tension is located, and exploring other characteristics of the tension such as shape, color, texture, location, and size. This aspect of containment is referred to as body awareness (Rothschild, 2000).

**Empowerment.** Empowerment gives the client a power stance rather than a victim stance. They are made to realize that they are in control of and can manage the situation. The trauma symptoms are no longer in charge (Bloom, 1997; Cohen et al., 2002; Herman, 1997; James, 1994; Rossman & Ho, 2000; Rothschild, 2000).

**Brain Gym®**

Brain Gym® refers to a program of exercises that promotes full brain activity with the intent of improving attention and focusing learning through movement. This program
was created by Dr. Paul Dennison, an educator in California. He based Brain Gym® on research findings in the areas of sensory motor training, applied kinesiology, and developmental optometry that connected the effects of movement to learning (Hannaford, 1995). Dennison utilized the research findings and made adaptations for children with learning difficulties. He identified simple, specific movements and developed them into 26 exercises intended to help children with developmental and learning disabilities and behavioral and emotional problems. In 1987, Dennison organized the Educational Kinesiology Foundation (Hannaford).

Neurobiological Basis

Dennison’s work has a neurobiological basis. At birth, infant growth and development are enhanced by human touch, which stimulates nerve endings leading to sensory motor growth and the development of spatial orientation and visual perception (Pearce, 1986). If this touch-induced stimulation does not occur, muscle movements are affected and sensory intake is limited. Over time, these conditions contribute developmentally to learning problems and emotional regulation (Hannaford, 1995). When touch is combined with other senses, a larger portion of the brain is activated. This strengthens and builds neurons and synapses, thus improving learning (Hannaford).

Movement is a sensory motor process that contributes to a child’s understanding of her/his environment (Hannaford, 1995) and is “essential to learning” (Hannaford, 2000, ¶ 1) and is important in integrating and anchoring new information into one’s neural network (Hannaford, 2000). Hannaford (2000) contends that moving in an organized fashion lends itself to “full brain activation and integration” (¶ 2). When
movement occurs, thoughts are anchored. Movement also assists in the development of blood vessels that carry water, oxygen, and other nutrients to the brain, all of which are essential for learning to occur (Hannaford, 2000).

Movement is connected to the senses. Not only does head movement align the sensory organs—eyes, ears, nose, and tongue—to the environment (Hannaford, 1995), but using the senses contributes to learning (Hannaford, 2000). For example, when one discusses new information to be learned, the “physical movements internalize and solidify” (¶ 4) the information in the neural network of the brain. During the process of talking, acetylcholine, a neurotransmitter, is discharged across synapses of activated neurons. This, in turn, stimulates the interconnections in the neural network (Hannaford, 2000). Although many children in many classrooms are taught to not move about during class, Hannaford (2000) contends that breaks should be taken every 7 to 10 minutes so that the eyes can restore the individual’s peripheral and three-dimensional vision.

Because it is through our senses that we develop an internal representation of the external world (Cicchetti & Rogosch, 1994; Perry, 2001a; Schore, 2002), the environment, in turn, can affect human responses (Hannaford, 1995). Smells can trigger memories; sound can stimulate images. Unexpected touching can cause a startle reaction while an expected, gentle touch can be soothing or calming (Hannaford).

At times of stress or danger, the eyes react in predictable ways, moving peripherally to absorb what is happening in the environment (Hannaford, 1995). When a child is constantly exposed to these chaotic, negatively charged environments, the outer eye muscles tend to strengthen, extending the inner eye muscles. This, in turn, does not
allow for normal foveal, or centered, focus. Additionally, tracking, or the left to right eye movement used in reading, becomes problematic (Hannaford, 1995). Traumatized children can appear to have their eyes focused on the side, giving them the appearance of being wall-eyed; that is, the right eye peers to the right while the left eye peers to the left. The eyes are not focused straight ahead. When traumatized children are requested to follow fingers or a pencil waving across their eyes, they complain that their eyes hurt; one can observe their eyes “jump.” As a result, these children have difficulty with reading and, therefore, are not motivated to do so. The Brain Gym® exercises are designed to reduce stress and “easily activate all the muscles of the eyes . . . and assist with ease of reading and comprehension” (Hannaford, 1995, p. 107).

Movement is essential for the normal development of a child. It contributes to crawling, walking, running, knowing where one is located spatially, balancing, and moving through the world. Movement is also instrumental in learning and thought processing (Hannaford, 1995). Hannaford (1995, 2000) says this is evidenced by observing people who need to be moving when studying or learning a new concept. They are seen to shake a foot or leg, tap a pencil, or twirl their hair. Others have reported insights while jogging, walking, or swimming.

Talking provides a pathway to organize and further detail thoughts. As an individual voices what has been learned, the physical process of using facial, tongue, and eye muscles solidifies the learned material throughout the neural network (Hannaford, 1995, 2000).
According to Maguire (2001), a “breakdown in performance is frequently a breakdown between the mind and body” (¶ 6). Brain Gym® can be used to help in bridging that gap by promoting communication among the nerve cells and functional centers of the brain and body (Maguire). Brain Gym® exercises also ease the learning process for children by reducing stress and improving self esteem (Brown, 2001; Hannaford, 1995).

Three dimensions–laterality, focus, and centering–are essential in brain functioning. Laterality involves coordination of one side of the brain with the other, particularly in the auditory, kinesthetic, and visual midfield, or area where the two hemispheres of the brain overlap. This is necessary for reading, writing, communication, whole-body movement viewed as fluid in nature, and thinking and moving at the same time. Coordinating the front and back areas of the brain is referred to as focus and is related to comprehension, finding meaning, and experiencing detail within contexts. Individuals without focus have attention disorders and difficulty in comprehending. Centering refers to the coordination of the top and bottom areas of the brain and is related to feeling and expression emotions, grounding, organization, responding rationally rather than emotionally, and sensing a personal space. Brain Gym® movements connect the brain in these three dimensions and allow the individual to learn through the senses, remember what has been learned, and participate in life (Important Stuff, n.d.; Maguire, 2001).

Because physical movements are known to stimulate the brain (Koester, 2002b; Maguire, 2001), Brain Gym® exercises activate communication, comprehension,
memory, and organization functions in the brain. Movement also contributes individuals to use the entire brain, thus releasing learning blocks and lessening “fight or flight” responses in favor of sustaining the memory and reasoning centers of the brain. Because the individual takes responsibility for and control of her/his learning by using Brain Gym® movements when they are necessary, a feedback loop is established and lends itself to improved performance and increased self-esteem (Maguire).

**Research Support for Brain Gym®**

Both formal and informal reports of the efficacy of Brain Gym® are available in the literature. Brain Gym® exercises have been successfully used in the United States and internationally with a variety of age groups—pre-school children, elementary school children, teens, athletes, business people, and aging Alzheimer patients. The exercises have been used to ameliorate learning difficulties and behavior problems; improve athletic ability; express creativity; reduce stress; improve vision, memory, coordination, listening ability, and self-expression; and cause improvements in attention, attitude, behavior, discipline, and test performance (Maguire, 2001). Unfortunately, many of the reported successes with Brain Gym® are anecdotal in nature rather than reports of actual research studies.

In one such study, 19 special education fifth graders were given a basic skills inventory as both a pretest at the beginning of the school year and a posttest at the end of the school year. Throughout the school year, the students participated in Brain Gym® exercises for 5 to 10 minutes each day. The results of the research indicated that the
students had gained one to two years in reading ability and comprehension and one-half of the students gained a year in mathematics (Hannaford, 1995).

In another study, 23 young male offenders in a California detention center were taught a Brain Gym® class over several weeks. The subjects showed “remarkable improvement” (Maguire, 2001, ¶ 3) in academic learning and increased self-control, particularly in the area of temperamental outbursts. At the beginning of the study, many of the young men spent time in solitary confinement. By the end of the study, none were in solitary confinement and all but two of the individuals had returned to their homes (Maguire).

Dr. Carla Hannaford was called upon to work with football players whose ages ranged between 14 and 16 years. These one time “good” players had lost self-control during their games, leading to penalties and game losses. Hannaford had the team members drink water and perform Brain Gym® exercises prior to each practice and game and during breaks. The team improved markedly, making their way to the state championship. During the first half of that game, self-control was strained. At half-time, the team assembled on the field and performed their Brain Gym® exercises. They ended the game victorious (Maguire, 2001).

At an elementary school in Ventura, California, Cecilia Freeman Koester and Joyce Sherwood worked with 12 teachers in grades 3, 4, and 5 and their students during the 1998-1999 school year. Working one hour each week during the school year, the teachers learned to determine the most appropriate Brain Gym® movements and activities corresponding to various learning experiences. They then guided their students
in those activities and taught the students to self-determine which movements they
needed at any given time. The students’ (n = 90) reading scores at the end of that school
year were compared to the previous year’s scores and to the scores of children in a control
group (n = 90). The students who used the Brain Gym® exercises improved their reading
scores between 55 and 89 percentage points, while the students in the control group who
received no Brain Gym® instruction saw gains between 0 and 16 percentage points. The
teachers, parents, and school administrators also reported a positive shift in student
self-esteem and attitudes toward school (Brain Gym® Improves Reading!!, 2000;
Koester, 2001, 2002a; Maguire, 2001)

In 1996, Gail Dennison and Diane Lehman used Brain Gym® with 15 preschool
children in Ojai, California in order to reinforce the development of posture, gross- and
fine-motor coordination, eye focusing, and listening skills, all done to prepare these
children, some of whom were at-risk, for learning. Several results were observed by the
teacher, parents, and researchers and included increased calm, attentiveness, focus, ability
to work cooperatively; improved motor coordination and movement; enhanced
vocabulary; enhanced writing and drawing skills; and better balance and standing posture
(Dennison, 2001).

In a study challenging the efficacy of Brain Gym®, Ferree (2002) studied 30
students in the 4th grade, assessing them on a battery of cognitive and behavioral
measures before and after the interventions. The students were randomly assigned to one
of three activity groups—the Brain Gym® group, a light aerobic exercise group, or the
social activity group. The groups met for 15 minutes each morning for five weeks. Ferree
found significant differences when comparing the pretest and posttest scores of the Brain Gym® and aerobic exercise groups to those of the social activity group. However, she did not find significant differences between the two physical exercise groups.

The lack of formal research on the use of Brain Gym® in improving learning and living was evident in the literature review. Because its proponents support its use and offer many anecdotal reports of its success, additional formal studies should and must be conducted to endorse or renounce its use as a learning tool.

**PACE Learning**

Carla Hannaford (1995), an educator and biologist, took three of Dennison’s Brain Gym® exercises and used them collectively. Known as PACE–Positive, Active, Clear, and Energetic–learning, the three exercises provide a learning readiness routine. The children begin by drinking water in order to hydrate the brain. This is followed, in order, by Brain Buttons, Cross Crawls, and Hook-Ups, three of Dennison’s Brain Gym® exercises. (Descriptions of the exercises are included in Chapter III.) According to Hannaford, these exercises should be completed three times a day.

**Brain Gym® and Traumatized Children**

Traumatized children are often in a state of hyperarousal or hypoarousal, that is, dissociated (Perry et al., 1996; Putnam, 1996). Because schooling is an important component in the lives of children, traumatized children who arrive at school in one of these states or enter one of these states while in the school setting are at a disadvantage for learning. Typically, these same children have difficulty with the social aspects of
school and often cannot modulate emotional responses and misinterpret social cues (Perry et al.).

In order to “learn” new information, the learner must be calm and focused and the frontal and cortical areas of the brain must be activated (Perry, 2002). Few traumatized children can accommodate this state since the brainstem and reptilian brain, are in operation and the areas of the brain responsible for higher levels of functioning—the limbic system, memory, and the cortex—are barely functioning (Perry).

When this occurs, the child cannot process the cognitive lessons being presented. The child’s ability to learn is not associated with intelligence. Rather, learning difficulties occur as different areas of the brain which control functioning and learning are activated by the reactions to trauma (Perry, 2002).

A traumatized child may have correct data stored in the cortical area, but may not be able to correctly respond when prompted about that data—when taking a test or participating in a classroom discussion. If the child is overwhelmed, the data will not be accessible, causing the child to once more experience failure (Perry, 2002).

When a child finds him/herself in an overwhelming situation, such as witnessing a violent action, the information needed to resolve the situation is in the cortex and, in the child’s traumatized state, is difficult, if not impossible, to access. According to Perry (2002), information learned in a song or rap is easier to recall in a state of hyperarousal than is information learned in traditional ways.

However, the movement involved in the Brain Gym® exercises can help the traumatized child focus and become more tranquil, allowing the brain to take in new
information and, therefore, cause the child to learn. The Brain Gym® exercises allow a traumatized child to relax, thus increasing the child’s ability to learn. This occurs because the exercises help to calm the brainstem and diencephalic brain, thus activating other areas of the brain and lessening the child’s hyperalert condition (Hannaford, 1995).

Summary

In Chapter II, an historical view of trauma, the history of PTSD and Dissociative Disorders as presented in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM), and the relatedness and differences of PTSD and Dissociative Disorders were discussed. It was pointed out that trauma diagnoses resulted from social upheavals and changes. These diagnoses result from overwhelming external events such as war, natural disasters, interpersonal violence, and child maltreatment.

Discussion continued regarding the internal effects of trauma on the developing child, particularly regarding attachment issues, developmental psychopathology, and the neurobiological effects. Additionally, risk factors were discussed; the focus centered on poverty as it pertained to rural areas. Finally, an overview of interventions for the treatment of traumatized youth was discussed. A review of the existing curricula and a discussion of Brain Gym® exercises was included.

It should be clear from the discussions in this chapter that the effects of trauma are multi-faceted. None of these factors can be considered in isolation but, rather, must be viewed in conjunction with other ameliorating factors. Particular emphasis was appropriately placed on the effects of traumatic events on the developing brain and the
inherent long-term consequences on the child’s functioning. The intricacies of the effects of traumatic events on the brain is a relatively recent area of research and should open avenues of thinking for clinicians and researchers.
CHAPTER III
METHODOLOGY

Overview

This chapter includes the rationale, theoretical framework, methodology, research questions, and analysis of this qualitative evaluative participatory study. The research was conducted at New Directions, a child and adolescent partial hospitalization program located in Perryopolis, Pennsylvania. The purpose of this study was to obtain the perspectives of those adults closely involved in the implementation of a developmental, sensory motor group trauma curriculum. Individuals in the community who oversee the partial program and who have an interest in the programs offered at the partial hospital program also were involved in the study regarding their views of the trauma curriculum on the milieu. The curriculum was initiated in January 2002. As of this writing, the curriculum is still in place. The collection of data occurred between March 17, 2003 and June 26, 2003. Five focus groups, three key informant interviews, and a discussion group held with the Pittsburgh Professional Society for the Study of Trauma and Dissociation (PPSSTD) were used to collect the data.

A qualitative research approach was used in this study to determine the perceived effectiveness of the trauma curriculum. Typically, a qualitative approach is used in research studies involving questions concerning process and understanding (Merriam, 1998; Patton, 1987). According to Merriam, the primary concern in qualitative research is “understanding the phenomenon of interest from the participants’ perspectives, not the researcher’s” (p. 6). According to Patton, “process evaluations are aimed at elucidating
and understanding the internal dynamics of program operations” (p. 23) and may be based on “observations and/or interviews with staff, clients, and program administrators” (p. 23). That is, process evaluations consider how a program is perceived by the staff and by those participating in the program. According to Patton, qualitative process evaluation is “developmental, descriptive, continuous, flexible, and inductive” (p. 23). In this type of study, the researcher pays close attention to how a “product or outcome is produced rather than looking at the product itself” (Patton, p. 23). This type of research requires that the investigator become familiar with the “day-to-day reality” (Patton, p. 24) of the program being studied. In this research, the partial hospitalization program staff’s viewpoints regarding trauma issues and the results of implementing the trauma curriculum were reviewed. I consulted with the New Directions staff twice monthly and attended and led most of the trauma groups over a one year period. I was responsible for developing the curriculum under study.

Rationale

*My Personal Voyage*

I have more than 27 years of experience in the mental health field. For the last 12 years, I specialized in the treatment of trauma, primarily with adults. For four years prior to conducting this study, my work included children and adolescents with trauma histories.

I worked full-time for 18 years on two very different adult inpatient units—the first 10 years at a community hospital mental health unit which operated on a medical model and eight years in a freestanding, inpatient psychiatric facility with a trauma track and
treatment program. While working with numerous trauma victims, particularly at the second facility, I became acutely aware that a segment of the inpatient population had repeated admissions presenting with similar symptoms including suicidal ideation, self-injury, hyperarousal, dissociation, and despondency. It was obvious that many individuals were motivated to improve, yet they were not getting better.

For eight years, Lakewood Hospital was open and located in Canonsburg, Pennsylvania (south of Pittsburgh). I worked in the facility from the time of its startup until its closing. It was there that I first learned about and began to understand and appreciate the effects of traumatic stress. At that facility, initial assessments included questions about abuse histories and when the abuse occurred developmentally—in childhood or as an adult. Further questions about traumatic events also were posed. The hospital had two consultants—one who specialized in trauma and another who was an art therapist—who worked with the staff over a three-year period, once each week to educate the staff and help staff members with interventions and treatment protocol.

One important memory comes to mind concerning the patients at Lakewood. Fire drills were held at the hospital on a regular basis. When a fire drill occurred on the unit, the staff would, invariably, be unable to locate all patients. Over time, the staff learned to look under the beds, in the armoires, and in other hiding places for “missing” patients. Typically, the patients were found either in a fetal position or motionless.

When some of the patients with “chronic trauma histories” were treated from a trauma perspective, positive changes began to occur in the patients. Also, the staff gained greater awareness and sensitivity regarding the disruptive behaviors that often occurred
on the unit. Terms such as safe place, grounding, containment, safety contracts, PTSD (Post Traumatic Stress Disorder), and dissociation became part of the “cultural” vocabulary of the unit. These phenomena were not discussed nor considered on the inpatient psychiatric unit of the community hospital (which operated under the medical model) in which I had served the previous 10 years. Adventure-based programming, expressive arts, psycho-education, and movement activities were used with the patients at the second facility and appeared to have a constructive effect on patients with traumatic histories. The interventions implemented with the patients provided support and encouraged growth. At that time, I believed that these interventions also served to decrease the hyperarousal and emotionally charged energy that often erupted in the unit.

Beginning in 1994 and continuing to the present, I actively participated in a study group that focuses on current issues including theories regarding trauma and dissociation. I have studied various energy therapies and was fortunate to be invited by PAAR (Pittsburgh Action Against Rape) to participate in a training series they offered. One of the training sessions was in EMDR (Eye Movement Desensitization and Reprocessing). Through the grant secured by PAAR, I am trained in both Level I and Level II EMDR. I gained many insights regarding the neurobiological effects of trauma. The information presented in the EMDR training further explained how the brain is involved in the information processing of traumatic stress. Later, when I worked with traumatized children, self study led me to the research of Bruce Perry, MD. His work focused on the neurobiologic underpinnings of trauma and the profound consequences caused by
childhood trauma in the developing brain. In 2002, I also had the opportunity to hear Perry speak at the EMDR International Conference in San Diego, California.

My Professional Journey

Because of my experience in dealing with trauma, in general, and the work I did with traumatized children and adolescents, I was asked to present an all-day training on the effects of trauma on children and adolescents. The training was presented to the teachers and clinicians at New Directions.

In the absence of a trauma curriculum at the facility, I was asked by the medical director, Dr. Mary Ann Pope, to create and implement such a curriculum for the children and adolescents at New Directions. At the time the curriculum was requested, the maximum occupancy for New Directions, as licensed in Pennsylvania, was 70 children and adolescents. It should be noted that the enrollment fluctuated during the study but never exceeded 70 at any given time. Seventy-two different young people—45 children and 27 adolescents—participated in the trauma groups at some time during the study. Three adolescents and one child went through the program twice. They were each counted once in the total count of 72.

The 72 children and adolescents who participated in the trauma groups were identified by staff report, the intake process, referral sources, or by parent or child self-disclosure as having a trauma history. Although all the children and adolescents were placed in the trauma groups at some time during their stay at New Directions, any particular group did not necessarily have the same members each time it met.
The Curriculum

In creating and implementing the curriculum, several issues had to be considered. A developmental aspect had to be incorporated into the curriculum. The clients ranged in age from five years to 18 years. This necessitated that different approaches be developed for the different age groups. The clients also exhibited varying levels of functioning. Some of the clients behaved in a regressed manner, that is, much younger than their chronological ages. These same clients also exhibited behavior beyond their stated chronological age. For example, a child of age six spoke about visiting the video store in a local community. She knew that the “nasty” movies (“You know, the movies where people have their clothes off and touch each other . . .”) were “upstairs in the store,” a location she was not allowed to visit. However, this same child could not read, was unable to sit still, and was impulsive. Her behavior and the “information” she could share were echoed in similar ways by other children in the program.

Additionally, many of the children and adolescents had learning and conduct disabilities. The learning disabilities included ADD (Attention Deficit Disorder), ADHD (Attention Deficit with Hyperactivity Disorder), and Dyslexia. The conduct disorders ranged from ODD (Oppositional Defiant Disorder) to Conduct Disorder. As a result of risk factors including high levels of poverty and unemployment, histories of neglect, maltreatment, and chaotic living environments, and due to the limited resources available in a small rural county, many of the children were unable to read or write.

In addition to addressing the variety of problems relating directly to the children and adolescents, the varied levels of education and training of the clinical staff were
additional factors. The teachers were certified as such in Pennsylvania. The therapists were, for the most part, entry level. All of them had at least a Bachelor’s degree and some had a Master’s degree; others were working on a Master’s degree. The therapists had varied educational backgrounds including education, child development, and social work. A few of the therapists had an understanding of the long-term effects of traumatic stress, however, most of the therapists had not received training in that area.

To best serve the interests of the children and adolescents in the New Directions program, I chose a sensory motor approach when developing the requested curriculum. The curriculum, which included movement components such as Brain Gym® exercises, target practice, and drawing, was presented to the children and adolescents when they were formed into the trauma groups. The activities used in the trauma groups are discussed in greater detail later in this chapter. Once the curriculum was written, it was put in place at New Directions. I then investigated the perspectives of the treatment team concerning the trauma curriculum as well as the impact of the trauma curriculum on the milieu. It must be noted that this study focused on the trauma groups and not on the entire partial program at New Directions.

*Children and Adolescents Enrolled in the Program*

A few words about the children and adolescents in the New Directions program are appropriate. Many of the children and adolescents had emotional outbursts that escalated, requiring the child or adolescent to be separated from the group, giving the child or adolescent time to think about the disruptive behavior. Eventually, the child or adolescent returned to the whole group. Separation from the group was sometimes
self-initiated. Often, the child or adolescent’s behavior may have necessitated removal from the classroom or, on the extreme end of the continuum, may have required physical restraint. The acting-out behavior often included yelling, swearing, name calling, throwing or breaking of objects, hitting, kicking, biting of self or others, or other disruptive behaviors that could cause harm to the individual, staff, or other students. Most of the children were unable to regulate their emotions or to recover immediately from their emotional outbursts. A cognitive behavioral approach was used at New Directions regarding treatment. Aspects of the trauma curriculum contained a cognitive behavioral dimension.

Research Questions

The purpose of this study was to examine the perspectives of the multidisciplinary treatment team regarding the inclusion of a trauma curriculum within the New Directions child and adolescent partial hospitalization program. The investigation was guided by three questions:

1. How did the trauma curriculum affect the child and adolescent partial hospitalization program at New Directions in Perryopolis, Pennsylvania?

2. What are the perspectives of the multi-disciplinary treatment team–professional staff, parents/caregivers, and county program specialists–and expert practitioners toward the trauma curriculum at the New Directions partial hospitalization program?
3. Have the perspectives of the multi-disciplinary treatment team–professional staff, parents/care givers, and county program specialists–changed concerning the concept of trauma and its effects?

The New Directions Partial Hospitalization Program

This research took place at New Directions, a children’s partial hospitalization program of the Chestnut Ridge Counseling Services, Inc. The New Directions facility is located in Perryopolis, Fayette County, Pennsylvania, a rural area in the foothills of Appalachia. Fayette County is one of the most impoverished counties in the Commonwealth of Pennsylvania, with 20.9% of the population and 29.9% of all children under the age of 18 living below the poverty level (Pennsylvania Partnerships for Children, 2001, December). Children and adolescents were referred to the New Directions program due to their inability to function in at least one domain, particularly the public school system. It should be noted that not all the children and adolescents at New Directions were identified with a trauma history, although a large percentage of them had been identified as such.

From January of 2002 through June of 2003, 10 trauma groups–five for children and five for adolescents–were conducted. When the groups were formed in January of 2002, the curriculum was six weeks in duration. By January of 2003, the duration of each trauma group was extended to eight weeks. Between 8 and 13 children participated in each of the children’s trauma groups. The adolescent trauma groups varied in size from five to eight participants. The children and adolescents did not participate in the study. Only adults who worked with the children and adolescents or who had interests in the
program were the subjects of the study. However, to better inform the reader of the process involved in this study, essential details associated with process are provided here; no details are offered that might compromise client confidentiality.

The clinical staff and teachers at New Directions identified and referred children and adolescents to participate in age appropriate trauma groups. While I did not take part in the selection of the participants, there were several exceptions. In one case, an adolescent requested permission to participate. Although the staff was reluctant to accommodate this request due to intrusive, autistic-like behaviors exhibited by the individual, I agreed to admit the student. At the onset, two sets of siblings were included in the same group. I requested that the siblings be separated. One set was agreeable when the situation was explained, while the other set refused to be separated stating they had always been together in all domains prior to entry in the partial hospitalization program. I suggested that the separation of siblings, other relatives, and best friends be respected in future sessions, and this request was honored in the trauma groups formed thereafter. In one of the adolescent groups, there was one participant of color among all other Caucasian participants. Although I inquired about the adolescent’s level of discomfort, offering to make changes, the participant maintained that it was not an issue. However, I noted the participant’s overwhelming silence while in the group. The student often would stop me in the hallway to offer a comment. I encouraged the student to share thoughts in the group. Unfortunately, the student was unable to do this in the trauma group and, several weeks after the group ended, reportedly informed the therapist that disclosure did not feel safe in that group due to the other members included in the group.
Participants

Children and adolescents were never directly approached about the trauma groups and their effectiveness. Rather, information was gathered from the adults who worked in the program, from the parents and caregivers of the children and adolescents enrolled in the program, and from others with direct knowledge of the trauma groups with vested interests in the New Directions program. Data collected reflected the perceptions of the adults. A group of adults who were not affiliated with New Directions in any way was consulted with respect to the trauma curriculum. In total, 43 adults participated in the study—39 in focus groups and four individual informants.

Focus Groups

All teachers, teacher aides, and mental health clinicians at the partial hospitalization program were invited to participate in one of the focus groups. Although no one declined, two individuals, both clinicians, left the program before the focus groups occurred.

Teachers and Teacher Aides

Three teachers, one of whom was designated as the lead teacher, two teacher aides, and one student teacher instructed both the children and adolescents. Although the student teacher was not present at the initiation of the trauma groups, she remained until the conclusion of the study. The teachers and teacher aides were present from the beginning of the trauma groups until the conclusion of the study. Focus groups were held with this segment of the research population on April 9, 2003 and April 28, 2003.
Clinicians

With the exception of one individual, the clinicians worked with either the children or the adolescents. One clinician began on the adolescents’ unit but was later transferred to the children’s unit. A total of 10 clinicians participated in this study. One focus group was held in April of 2003 to discuss the children’s trauma groups. Six clinicians participated in that focus group. A second focus group was held in May of 2003 to discuss the adolescents’ trauma groups. Five clinicians, including one individual who also participated in the children’s focus group, participated in the second focus group for clinicians.

Parents/Caregivers

Two focus groups were held with the parents and caregivers of the children and adolescents who participated in the trauma groups. The first focus group was incorporated in a meeting held on April 24, 2003 with the parents and caregivers. At that meeting, I made a presentation concerning trauma and children. Following the presentation, the remainder of the allotted meeting time was devoted to the focus group. Seven parents/caregivers participated in that first focus group. A second parent/caregiver focus group was held on Family Fun Day (June 3, 2003). Eight parents/caregivers participated in the second focus group. Only one individual participated in both focus groups. Both focus groups were held at the New Directions facility.

Key Informant Interviews

Key informant interviews were held with members of the multi-disciplinary team—the medical director, the psychiatric nurse, and two specialists at the county level. A
focus group had been planned with six county-level individuals. Due to other commitments, however, only two of the six were able to meet with me. After consulting with my committee chair, it was decided that the information gathering meeting with them would be considered a key informant interview with two individuals.

*County Specialists*

I telephoned the Fayette County Mental Health/Mental Retardation offices and invited key personnel familiar with New Directions to participate in a focus group. A call also was made to the representative of the managed care company for the county. While these individuals are not directly involved in programming at the partial program and have not observed the trauma groups, they do oversee the program for Fayette County and make referrals when indicated.

On the day of the scheduled meeting, March 17, 2003, two of the invited individuals were available. The first individual was the Fayette County Mental Health/Mental Retardation Program Specialist whose responsibility it was to oversee special programs for the children and adolescents in the county who qualified for such programs. The second individual was a representative of the insurance company that authorized treatment for the children and adolescents. I proceeded with the joint interview held at the Fayette County Mental Health/Mental Retardation office and considered it a key informant interview due to the number in attendance.

*Medical Director and Psychiatric Nurse*

Key informant interviews also were held with the medical director of the facility (April 14, 2003) and the psychiatric nurse at New Directions (April 26, 2003) and with
Both interviews were held at the New Directions facility. A total of three key informant interviews, involving four individuals, were held.

**Expert Practitioner Focus Group**

I provided copies of the trauma curriculum to members of the Pittsburgh Professional Society for the Study of Trauma and Dissociation (PPSSTD) who read and critiqued the curriculum. Although this organization is not affiliated with New Directions, and their members have never seen the trauma groups in operation, they were able to make unbiased comments regarding the curriculum. I met with a representative group of eight individuals on June 2, 2003. The meeting was held at the Friends Quaker Meeting House in Pittsburgh, Pennsylvania.

**Theoretical Framework**

For the purpose of this research, an evaluative case study was used to examine the effects of the developmental trauma curriculum written for the children and adolescents at the New Directions children’s partial hospitalization program in Perryopolis, Pennsylvania. According to Patton (1987), a case study is used when one needs “to understand some particular situation in great depth and where one can identify cases rich in information—rich in the sense that a great deal can be learned from a few exemplars of the phenomenon in question” (p. 19). In this study, the impact and outcomes of a trauma curriculum designed specifically for programming at New Directions were evaluated by adults associated with the program. The curriculum, which had a sensory motor focus, also was evaluated by professionals in the field of trauma. These professionals were not affiliated with the partial hospitalization program which served as the site of the study.
The curriculum was designed to introduce the concept of trauma to the children and adolescents at New Directions. In addition to providing the children and adolescents with an understanding of trauma, the curriculum was designed to enhance their coping skills for self-regulation. Because the children and adolescents were organized into groups when the trauma curriculum was presented to them, the term “trauma groups” evolved.

This study investigated the perceptions of the staff, administrator, and other vested adults regarding the impact of the trauma curriculum on the children and adolescents enrolled in the New Directions children’s partial hospitalization program. The study also investigated the perspectives of the staff regarding the concept of trauma. It was anticipated that different meanings would emerge through the research process.

Although this research clearly was conducted with adults who were vested in the lives of the children and adolescents at New Directions, the structure of this study depended upon an understanding of the curriculum used with the children and adolescents. For this reason, the individuals most familiar with the curriculum—the professional staff at New Directions—and the parents of the children and adolescents were interviewed in several focus group settings. Expert practitioners in the area of trauma were also interviewed regarding the trauma curriculum. Unlike the staff and parents, they were not familiar with the curriculum; however, they could add a rich perspective due to their expertise in the field of trauma.
Curriculum

*Sensory Motor Exercises*

A discussion of the sensory motor exercises used with the children’s and adolescents’ trauma groups follows. Understandably, not all exercises were used in each session. Some of the sensory motor exercises were taken from Dennison’s Brain Gym® program, others were taken from other sources, still others were designed by the researcher. A discussion of the exercises follows.

Prior to beginning many of the activities, the group leader discussed the personal strengths each human possesses, strengths that help in dealing with traumatic events. The group leader also might discuss how trauma may have affected those strengths in either positive or negative ways.

Often, one of several exercises may have been appropriate for a given trauma group session. One approach taken was to have the group leader briefly describe the activities, providing examples. Once the projects were described, the group decided which one would be completed. The group members voted with the majority vote ruling.

*Brain Gym® Exercises*

Several of the exercises used to begin each trauma group session were derived from the Brain Gym® program developed by Dr. Paul Dennison, an educator in California, in the 1970s. Dennison based his program on research findings in the areas of sensory motor training, applied kinesiology, and developmental optometry that connected the effects of movement to learning (Hannaford, 1995). Dennison emphasized that movement is essential for learning and that increasing motor skill improves
communications and academic achievement. Additionally, he contends that the Brain Gym® exercises contribute to the skills necessary for working cooperatively with a team and contribute to self-esteem and self confidence (Cohen & Goldsmith, 2000).

Researcher Carla Hannaford (1995), a biologist and educator, has conducted research in the area of movement and learning and uses Dennison’s Brain Gym® exercises. Hannaford extracted three of the Brain Gym® exercises–Brain Buttons; Cross Crawls, and Hook-Ups–and coined the term PACE (Positive, Active, Clear, and Energetic) learning to designate the sequence. When used together, the PACE exercises act as a learning readiness routine. The Hook-Ups were also known as Gentle Crossovers (Hannaford, 1995) and The Pretzel, a name given to the exercise by the children at New Directions.

While Hannaford (1995) recommends that these exercises be completed three times a day, they were used as the first daily activity in each of the 45-minute trauma groups for both the children and the adolescents. When time remained (approximately 25% of the time), the Pretzel and Positive Points were used to close a trauma group. The children also were told to use these exercises when learning a new concept or to alleviate the stress associated with certain situation they encountered throughout their day. According to Hannaford, these simple physical movements activate whole brain functioning, particularly in the frontal lobes. Brain Gym® “activates full mind/body function through simple integrative movements which focus on specific aspects of sensory activation and facilitate integration of function across the body mid line” (Hannaford, 1995, p.112). The exercises, which are based on the practice of sensory
motor training, were used to promote learning and increase attention or focus in the children and adolescents.

*Brain Buttons.* Brain Buttons is a breathing exercise. In performing this exercise, the participant places one hand over the navel area. The other hand is stretched somewhat so that the thumb is placed under the clavicle (the bone that sticks out on the upper chest to the right and left of the sternum, or bone in the center of the chest) and the index finger is placed beneath the clavicle on the left side, to the left of the sternum. The participant then inhales and exhales slowly three times while simultaneously using the fingers to gently rub the two points on the upper chest. It is believed that his action stimulates the blood flow through the carotid arteries to the brain (Hannaford, 1995). Brain Buttons was the first exercise performed at the beginning of each trauma group. It was followed by Cross Crawls.

*Cross Crawls.* While Cross Crawls may be done in either a sitting or standing position, most of the children sat because they could not maintain balance otherwise. Cross Crawls are performed slowly. The participants are directed to touch their left knee with the right hand while lifting their left foot off the floor. While the left knee is being drawn up from the floor, the right hand is moving down to touch the left knee. They alternately tap the right knee with the left hand and the left knee with the right hand. (One variation of this exercise is to touch the elbow to the knee.) This exercise activates large portions of the left and right brain hemispheres, increases communication between the two hemispheres, and helps improve high level reasoning (Hannaford, 1995).
The Pretzel. The last of the three exercises described in the Brain Gym® literature as Hook Ups, was renamed the Pretzel by the first group of 5, 6, and 7-year-old students. The children said it felt and looked like a pretzel, so the name stuck. The Pretzel is intended to be used as a coping skill for affect regulation and relaxation.

In performing the Pretzel, the participant crosses her/his ankles. The arms are stretched in front of the body with the backs of the hands touching. One hand is then crossed over the other at the wrists; palms are now facing each other. The fingers of both hands are then interlaced. The clasped hands are then rolled downward toward the floor and then up to the chest, where they rest; the elbows are pointing downward. This exercise can be done in a prone, standing, or sitting position. This position is held for 45 to 60 seconds. The participant’s tongue rests against the roof of the mouth. In one perspective, as taken from Eastern philosophy, this allows for the internal energy, chi, to flow in a uniform direction.

From the Brain Gym® perspective, this exercise “connects emotions in the limbic system with reason in the frontal lobes of the cerebrum, thus giving an integrative perspective from which to learn and respond more effectively” (Hannaford, 1995, p.120). This exercise was used as a calming exercise. When the children performed the Pretzel, they always were encouraged to think positive thoughts. Approximately 25% of the time, the trauma group would be closed with the Pretzel and a positive thought about the rest of the day. This did not happen on a regular basis due to time constraints.

Positive Points. An additional Brain Gym® exercise that was introduced on occasion was Positive Points. In performing this exercise, the individual gently rubs
pressure points located above the middle of each eyebrow. While this is done, the individual thinks positively about her/himself or about what he/she wants to accomplish. While this exercise was used more often with the children than with the adolescents, it was introduced to both.

Lazy Eights. This exercise is known as both Lazy Eights (Dennison & Dennison, 1985) and the Infinity Walk (Sunbeck, 1996). Sunbeck adapted Dennison’s Lazy Eights exercise and attached the new name. Although Sunbeck’s adaptation was used in the trauma groups, it was referred to as Lazy Eights when the exercise was utilized.

This exercise was used in the children’s group. Two chairs are placed four feet apart from each other. The children lined up behind the group leader. Starting between the chairs, the children follow the group leader in a figure eight pattern around the two chairs. The exercise is repeated three or four times. Once the children were accustomed to the pattern, one of them would serve as the leader. They were encouraged to add a movement to the exercise. Their additions included increasing the pace, touching each finger with the thumb as they walked, humming or singing a song, rotating their arms, and tapping their shoulders.

Expressive Arts

Often, expressive arts were used with the children and adolescents in the trauma groups. Some of these exercises were adapted from the work of others and some of them were developed by the researcher.
Environment Project

Adapted from Sokol and Schneider (1998), this activity was aimed at the creation of a safe environment. Each student was encouraged to select a plastic figurine and, given an 8×11 sheet of poster board and other art materials—glitter glue, paint, markers, crayons, glue, beads, shredded paper, ribbon, foam forms, craft sticks—was asked to use it in any creative manner the participant chose, creating a safe environment for the figurine. Each was encouraged to consider what the figurine would need to feel protected using only the provided materials. This process took two or three sessions to complete. The children or adolescents then presented their projects to the group and explained the safe environment they had created. They also discussed their feelings about completing the project. Others in the group provided feedback on each project.

Inside-Out Box

This project required several items—a shoe box for each participant, wrapping or shelf paper to cover the box, glue, construction paper, magazines, ribbons, buttons, glitter, and odds and ends of craft items. Each individual decorated the outside of their box to demonstrate how they believe the people in their world see them. The inside of the box was decorated to indicate how the individual felt on the inside, what they determined to be the "true self." The lid was kept separate from the box. This exercise took one-and-one-half sessions to complete. The participants could talk with each other as they worked or offer items to others in the group (Cohen, Barnes, & Rankin, 1995).
**Self Portrait**

This activity was used exclusively with adolescents. The participant laid down on a sheet of newsprint that was as long as the person was tall. The adult leaders outlined the individual’s body with pencil. It was then up to the adolescent to fill in the outline, using various craft items, and create a collage of how they believed others perceived them. They were asked to include things that represented how they felt about themselves on the inside of the lines. This activity created some anxiety concerning body image issues, but it also evoked excitement in producing a large project.

**Group Environment Project**

The group environment project was used exclusively with the children’s groups. Each group was divided into three or four subgroups, each containing three or four children. Each subgroup selected a large poster board and was given instructions to create a safe community, that is, how they believed a safe neighborhood would appear.

In one session, the subgroups identified and wrote out safe rules, that is, rules by which one would live in the community or neighborhood. In other sessions, the children were encouraged to use plastic figurines of people, animals, and vehicles; beads; stickers; foam shapes; grass; construction paper; markers; paint; glitter glue; sequins; craft sticks; toothpicks; and any other item they chose in order to model their safe community. This project usually took four or five sessions to complete. Another session offered the group an opportunity to process about their creations. I created this project with input from the clinical staff.
Magazines

A stack of old magazines was made available to one group with the instructions that the group members look for pictures that, to them, represented something they would like to get rid of. They were to rip those pictures from the magazines.

A medium-sized box was placed in the center of the group. Each member would show her/his picture to the group, describe what they were getting rid of, and tell what it meant to them. They would then crumble the picture and throw it into the box. As an individual was discussing a picture, the other group members were encouraged to enter into the discourse. After all of the group members got rid of their pictures, all the members of the group carried the box and, collectively, emptied it into the trash can to be sent out with the garbage. The group members would then resume their seats and discuss the positive things they could use to replace the items they had thrown away.

At another time, the groups were given stacks of old magazines and told to look through them and tear out two or three pictures or words that represented something they believed the world could live without. Each individual would then show the group what they had selected and explain why they had chosen that item. Once the participants had discussed their items, they decided whether or not they wanted to destroy the picture or word.

Play Dough

Play Dough was introduced as a medium to be used to manage out-of-control feelings and tension. First, the participants were asked to visualize their anger. As they did so, they were asked to pay attention to the location of the anger in their bodies and to
attribute to it shape and color or colors, if possible. They then sculpted their anger as they saw it, using the Play Dough. They were asked to pay attention to the level of their anger as they created the sculpture. Each member then displayed their sculpture of anger and addressed the issue or issues to which the anger was connected.

Other Exercises

In addition to the Brain Gym® and expressive arts exercises, several others were employed. A discussion of these exercises follows.

Magic Circle

Magic Circle was utilized in the first session of each group as an ice breaker and to build group cohesiveness. Each member of the group was asked to share information about a favorite possession or to tell what was most important to them. After the third person spoke, a volunteer from the group was asked to restate the items shared by the three individuals. If the volunteer faltered and could not recall the items, the other group members would help in the spirit of support. The next three students were asked to share their information. Then, a volunteer was asked to repeat all six items with, of course, the help of the group when needed. This process continued until all members of the group had shared their information.

Safe Place

During the first week of the trauma groups, discussions focused on “happy” or “safe” places. Each student drew a picture of their safe place(s). They then verbally processed their drawing experience with the group at the next session. This exercise is basic to trauma therapy and is used in treatment as a way to remain grounded and to
regulate affect whenever a disturbing thought or feeling occurs, particularly one associated with a visual image. The students were told to think about their safe place(s) when they felt overwhelmed or experienced a feeling of “leaving” the present. It was intended to anchor the students when such a situation occurred so that they could maintain and stay in the present (James, 1989; Rothschild, 2000; Shapiro, 1995; Steele & Raider, 2001).

For the adolescent, the “safe place” is a special place that is calm, peaceful, and pleasant. In that place, the adolescent is in charge; no one can enter this place without the individual’s permission. Examples include: fishing on a lake, hiking or walking in the woods, a beach scene, a mountain scene, floating on clouds, a rainbow, sitting on a neighbor’s or grandparent’s front porch, swinging on a swing in a park, and watching the snow fall. The students are then directed to go to the tables and draw their “safe places.” Paper, crayons, and markers are provided. When all drawings are completed, the students are directed back to the circle where they are encouraged to share their drawings and describe their “safe places” in a narrative form. The group leader reinforced their efforts and explained that the “safe place” image should be used whenever they feel anxious.

Target Practice

Target Practice, adapted from Beverly James (1989), is an exercise in which the individual draws a picture or target that represents something about which the individual is angry or upset. The picture, or target, is then hung on the wall using tape or another adhesive. I introduced the use of a throwback ball which is a three-inch hard rubber ball that has a piece of elastic sewn through it. The elastic is about 5 feet in length. At the
other end of the elastic is a wrist band with velcro that the person wears on the wrist of one hand while throwing the ball with the other hand. The target is the picture hanging on the wall. When the ball attached to the elastic returns to the person, the individual is to catch the ball and continue the process.

While this exercise reinforces hand-eye coordination, it can be intimidating for some children. As the child throws the ball, he or she is encouraged to yell out words or sounds. Other members of the group rally around their peer and provide encouragement. Some children need the group encouragement in order to throw harder. If the child does not stop after making between six and nine pitches, the leader intervenes. It is important to not allow any one child to go on endlessly since this can contribute to a dissociative episode which must be avoided. The intent is to assist the child with affect regulation. The student may then choose to share what they experienced with the others in the group. The group members give feedback regarding what they noticed or experienced.

*Butterfly Hugs*

Butterfly Hugs is a self-administered exercise that uses bilateral stimulation. The exercise was developed by a Mexican therapist, Lucy Artigas, while working with children who survived Hurricane Pauline. It was then implemented by Ignacio Jarero in the “Group Protocols for Work with Children Survivors of Traumatic Events” (Cloyd, 2000; Mexican Association for Crisis Therapy, n.d.).

The child places her/his right hand on the left shoulder and the left hand on the right shoulder, crossing the arms over the chest. The child then thinks of something that
provides comfort. The child then alternates tapping the left and right shoulder with the opposite hand.

This technique is used with EMDR (Eye Movement Desensitization and Reprocessing) and is thought to provide empowerment to the children as they control the tapping and use their own imagery for calming and self-soothing purposes. The children were told that this exercise could be used to help with sleep problems or when they were feeling worried or upset. They were encouraged to use the exercise when needed throughout their day in the partial program.

*Imagery*

Imagery also was used with the students to help them cope with upsetting, frightening, or overwhelming visuals and transform them into more manageable thoughts. Examples include a super hero, guardian angel, or protective animal or person. An integral part of the group learning experiences, this technique was designed to replace the disturbing situation or image with one that empowered the individual.

*Mind Mapping*

Mind Mapping a technique used in the adolescent groups. In this activity, the word “trauma” was written in the center of a large piece of blank newsprint. The students then sat around a table on which the newsprint was placed. On a part of the paper in front of them, each participant then wrote a word they associated with the word “trauma.” The paper was then rotated one location so that the word of an adjacent student was now in front of each adolescent. They were instructed to write a word they associated with the “new” word in front of them. The students were permitted to talk during the exercise and
help each other. This continued for approximately 15 minutes. The group then discussed
the words that evolved on the paper and the associations the group had made with the
initial word “trauma.” The aim of this intervention was to view trauma in a broad sense.

This exercise was usually done in the second or third group session. It was
repeated during the last week of the group. The results of both experiences were
compared and contrasted by the group.

Music

Music was incorporated into the adolescent groups. On several Fridays, a
participant would bring in one or two songs that they liked and had special meaning for
them concerning their own traumas or struggles. The staff cleared the music before the
group began. Profanity and abusive language were not permitted. The participants would
relate the song’s meaning to the group. After listening to the song, the group would
discuss what they heard and how it affected them.

Moon Ball

This exercise was adapted from one used at Lakewood Hospital where I had
previously worked. It was used in both the children’s and adolescent’s trauma groups,
particularly if the energy in the group dropped or if the group was having an “off day.”

This exercise requires the use of a beach ball. Everyone, including the staff, sat in
a circle. The group was told that they had to keep the ball moving while remaining in
their seats. Although, they could stretch to bat the ball, they had to remain seated. The
ball could land on a table or desktop or bounce off of something. One person could tap
the ball several times in a row or tap the ball with their head or foot. Once the ball landed on the floor, the round was over.

At the beginning of the exercise, the group, as a unit, decided on a goal. For example, they may have decided to keep the ball in volley for a count of 25. (The leader would keep the count.) Once that goal was met, the goal of the next round was set higher. Members of the group were encouraged to offer suggestions to their peers, particularly when their peers were having difficulty.

Moon Ball tended to elevate the group’s energy, which then contributed to an increase in the group process and added to group cohesion. This was used several times in each of the groups. The outcome was always positive.

Research Design

Qualitative Approach

Qualitative studies allow a researcher to obtain an in-depth understanding of a phenomenon and explore the meaning of a situation from the viewpoint of the participants (Merriam, 1998; Patton, 2002). In qualitative research, “the interest is in process rather than outcomes, in context rather than a specific variable, in discovery rather than confirmation” (Merriam, p. 19). Responsible for both data collection and analysis (Merriam; Patton, 1987, 2002), the qualitative researcher goes to the setting and observes the culture or phenomenon under investigation. This type of study utilizes an inductive strategy, allowing for a theory to evolve from the process of observing and studying the situation (Merriam; Patton, 2002).
In the study being reported here, I employed a qualitative evaluative process approach since the personal experiences of all those involved and observed could provide an in-depth understanding of how the use of a trauma curriculum in a children’s partial hospitalization program affects the various components of the program. This type of qualitative method entails describing the details of a program based on observations of and interviews with staff, administrators, parents, and other interested parties (Patton, 1987).

The trauma curriculum had been in place for over a year before the interviews reported in this study took place. During that time, the staff—particularly the therapists—were consulted on a regular basis regarding the implementation of the trauma curriculum. The adaptability of the program allowed for changes to occur to meet the immediate needs of a particular group. Once the program was in place, the evaluation process reported in this document took place. Patton (1987) contends that it is “important to know the extent to which a program is effective after it is fully implemented” (p. 27). He goes on to state that “until the program is implemented and a ‘treatment’ is believed to be in operation, there may be little reason to even bother evaluating outcomes” (p. 27). Patton refers to these as implementation evaluations and says they tell decision makers “what is going on in the program and how the program has developed” (p. 27). Such studies require “case data rich with the details of program content and context” (p. 28).

In order to achieve the goals of this investigation, I employed an observer-participant approach. I became acquainted with the staff at New Directions and interacted with the children and adolescents in order to obtain what Patton calls an “inside
view” (1987, p. 75) of what was happening at the facility, thus providing me with a sense of what it was like to be in the program. Clearly, there also was a need for me to serve as an observer, therefore, I had to continually assess for a balance between the two roles—participant and observer. While it is obvious that I could not become a student, my participation as a group leader lent itself to formulate an insider’s perspective (Patton). I was very involved with the program at New Directions—I wrote the curriculum with staff input, attended most of the trauma group sessions, ran the groups to train the therapists, conducted the focus groups and interviews with the key informants, and conducted case consultation meetings with the staff twice a month throughout the year.

Evaluative Case Study

While there are many approaches to qualitative research, I chose an evaluative process layered case study of the trauma groups in the partial program as the focus of this research. In a layered case study, the investigator has the ability to study multiple participants who operate at different levels, or layers, of an organization (Patton, 2002). Each case is referred to as a unit of analysis (Patton). In this study, I gathered the perspectives of the therapists for the children and the adolescents, the teachers and teacher’s aides, the parents, the nurse, the administrator of the facility, and individuals outside the facility with vested interests in the programs at New Directions. In addition, as a means for enhancing trustworthiness of the results, the researcher also conducted a focus group with the members of an independent study group comprised of experts in the field of trauma. While these individuals were not familiar with the curriculum
implemented at New Directions, they were interested in its theoretical orientation, content, and design.

Each component of the program, as well as the program itself, became a unit of analysis. Patton also stated that a researcher can establish larger case units from smaller ones by combining the study of several individuals into the study of a group or program. Bernard urges that the researcher “always collect data on the lowest level unit of analysis possible” (1995, as cited in Patton, 2002, p. 448). The data collected on individuals can then be aggregated to describe the overall program.

A qualitative case study permits an enhanced view of a group’s process and allows the researcher to observe the participants’ emotions and hear their thoughts and perspectives (Merriam, 1998). Qualitative study requires the data collector to be sensitive to both the phenomenon being studied and its meaning to the participants. This sensitivity must continue from data collection through data analysis (Patton, 1987). Because a case study allows for an intense look at the phenomenon under scrutiny, a researcher often seeks the perspectives of a variety of people with different relationships to the program including those inside the organization (who provide what is called the *emic* view) and others from outside the organization (who provide what is called the *etic* view) (Patton, 2002). In this particular study, the perceptions and reactions of many inside sources—the clinical staff, the teachers and aides, the nurse, and the administrator—and several outside sources—a county representative, a county insurance representative, and members of PPSSTD—were closely studied. Their views on the trauma curriculum and its
implementation were the focus of that study. Many perspectives were obtained throughout the process.

A study is said to be “bounded” if the number of observations, the number of participants, or the duration of the study is limited (Merriam, 1998). According to Merriam, a case study, by its very nature, is bounded. In this study, the number of participants, the number of focus groups, and the duration of the study were limited in some way. Individuals could elect to participate in the study, that is, no one was coerced to participate. In order to lessen disruption of the normal routine and not overly inconvenience participants, a limited number of focus groups was conducted. The study did not begin until the trauma curriculum had been in place for a school year.

Sample Selection and Size

There are two basic types of sampling—probability sampling and nonprobability sampling. Simple random sampling, the most common example of probability sampling, allows a researcher to generalize study results from the sample to the population from which the sample was drawn. This type of sampling is not applicable in qualitative research, since such statistical generalizations are not the goal. Therefore, nonprobability sampling methods are used in qualitative research to determine what has occurred, the implication of what has occurred, and any relationships between what has occurred (Merriam, 1998).

The most familiar form of nonprobability sampling is called purposeful sampling (Merriam, 1998). Qualitative research samples are usually small and “selected purposefully” (Patton, 2002, p. 230) providing “information-rich cases” (p. 230). The
subjects in such a sample are those who can inform the researcher about the phenomenon under study. The sample must be selected relative to the purpose and rationale of the research (Patton).

Several sampling methods were used in the reported investigation. “Combination sampling” and “mixed purposeful sampling” are the terms used by Patton (2002) to refer to sampling in which more than one strategy is used. In criterion sampling, all cases that “meet some predetermined criterion of importance” (Patton, 2002, p. 238) are selected and studied. Since all the participants in the study had an awareness of the trauma groups, I reviewed those participants (cases) because they had the predetermined characteristic of relevance to the research.

Emergent sampling was implemented as this requires that the qualitative researcher make decisions about taking advantage of opportunities that can occur while doing data collection after the fieldwork has started (Patton, 2002). After the study was underway, I decided to add the focus group consisting of members of the PPSSTD.

The addition of the PPSSTD focus group also is an example of theory-based sampling, as this group is committed to the study and evolving construct of dissociation and trauma. While the group is not related to the partial trauma groups, it does have an interest in trauma. In qualitative research, combining methods in sampling is common and strengthens the study (Patton, 2002).

In qualitative research there are no set rules concerning sampling size. In general, sample size is related to the purpose of the research, what is credible, what is useful, and what can be done with the availability of resources. The insight and meaningfulness that
evolve from qualitative studies are more related to the information richness of the cases than with the size of the sample. In general, the sample size must be large enough to answer the question or questions posed at the beginning of the study. According to the qualitative research literature, sampling ends when no new information comes from the samples selected (Merriam, 1998; Patton, 2002).

In the study reported in this document, the researcher included in the sample all staff at the New Directions facility, realizing that the sample size could be expanded by the identification of key informants identified in the initial sample or identified in a related aspect of the fieldwork. Five focus groups were conducted and included teachers and teacher aides, child therapists, adolescent therapists, and two groups of parents. In addition to these groups, a special discussion group with clinicians who had a primary interest in trauma was added. Key informant interviews were held with the chief administrator and the psychiatric nurse from New Directions. A key informant interview was also held with two individuals, a representative of the Fayette County Mental Health/Mental Retardation (MH/MR) Office and a representative of Health Choices, the medical insurance company that insures many of the children and adolescents at New Directions. It should be noted that these participants were not directly affiliated with New Directions.

Methodology

I met with the staff at New Directions in small focus groups. These focus groups were organized by job descriptions. Five focus groups were conducted, each lasting about one hour. One focus group was held with the children’s clinical staff; a second group
consisted of the clinical staff members who work with adolescents; the third group included the teachers and teachers’ aides; the last two focus groups were held with parents. There was a followup meeting with the group consisting of the teachers and teachers’ aides.

Focus Groups

The New Directions staff was invited to participate in the focus groups first by way of an announcement I made at a case consultation meeting that I led twice each month and also by personal invitation. Prior to meeting with any constituency, I asked the participating individuals to identify convenient dates and times for the meeting. Although focus groups are generally comprised of six to eight members (Krueger & Casey, 2000), one of the groups had five members and included all of the available adolescent therapists.

The focus groups were organized in order to collect data concerning the effectiveness of the trauma groups held with the children and adolescents. These group meetings gave the staff an opportunity to discuss their experiences with the trauma groups; their views concerning the impact of the trauma curriculum, including its strengths and weaknesses, on the children, adolescents, and overall program at New Directions; and their understanding of trauma and its effects on children and adolescents. I served as the facilitator of the focus groups and presented questions informally in order to encourage dialogue within the groups. All of the focus groups were audio taped for both convenience and accuracy. The groups occurred in the natural setting, that is, they were held at locations where the participants would normally meet.
The parents were invited to a regularly scheduled parent’s meeting where I made a presentation regarding trauma and children and address the trauma groups that had been in effect. Based upon consensus, a focus group with the parents followed that presentation. Parents who attended the annual Family Fun Day also were invited, that day, to participate in a focus group because transportation is a very real problem for the population served at New Directions. The meetings with the parents were conducted in this fashion. Both the director of the facility and the staff were supportive of this method of collecting data from the parents. I led the focus groups with the parents and asked questions to elicit responses that would assist in answering the research questions posed in this study.

*Key Informant Interviews*

In addition to audio taping the focus groups, data were collected through interviews, observations, taking of field notes, and the review of documents (Merriam, 1998). I personally approached each key informant for their input. Key informant interviews were held with the medical/clinical director and the psychiatric nurse from New Directions and two county representatives.

*Expert Practitioner Group*

I felt that this study would be strengthened by asking a group of expert trauma practitioners to examine and consider the preliminary research results. The writer approached the trauma study group, PPSSTD, with a verbal request for their participation. The issue of participating in the study was discussed during a regularly scheduled monthly meeting. The members agreed to participate in the study and scheduled a focus
group for June of 2003. Prior to the focus group, the members were asked to review the curriculum from a clinical perspective. Their responses added another perspective to the research because of their experience and expertise in the area of trauma. The addition of this expert practitioner group served to triangulate preliminary results and to enhance the trustworthiness of the study. This is consistent with Levers’ (2002, 2003) suggestion that “cultural experts” can assist in validating preliminary findings.

Ethical Considerations

I discussed informed consent issues with the participants at the beginning of the focus groups and before starting the individual interviews. I also provided a detailed description of the focus group and individual interview protocols.

The informed consent document included a list of the risks and advantages associated with participating in the study. Each adult participant was required to sign the Consent to Participate form, which indicated that the qualitative research was being conducted as part of my dissertation requirements at Duquesne University. I agreed to stop the interviews, should the need arise, in order to process with any participant who made such a request. Participants who had an adverse reaction to the focus groups were encouraged to meet and discuss concerns individually with me. The participants also were required to sign a second informed consent form that indicated that the session was being audio taped and would later be transcribed in order that the data could be analyzed.

I am a licensed professional counselor (LPC) and have an extensive history of conducting trauma therapy. Currently, I am employed at Chestnut Ridge Counseling Services, Inc. as an outpatient therapist and consultant with a specialty on trauma. Also, I
am a consultant with New Directions, the children’s partial hospitalization program where the research was conducted. I currently have two private practices–Soul Repair in South Fayette Township, Pennsylvania and Wellness Promotion, Inc. in Uniontown, Pennsylvania.

In addition to providing mental health services, I am a consultant for Fayette County Children and Youth Services and a consultant to the clinical supervisor at Pittsburgh Action Against Rape (PAAR). I just completed two years as the president of the Pittsburgh Professional Society for the Study of Trauma and Dissociation (PPSSTD), an affiliate of The International Society for the Study of Dissociation (ISSD). I have been a member of this organization since 1994, have held various other offices, and have co-chaired two major conferences on trauma including one for Bessel van der Kolk in 1997. In November 2002, I co-chaired “The Traumatized Child” conference that featured Joanna Silberg, Ph.D. and Frank Putnam, MD. Also, I am Level Two EMDR (Eye Movement Desensitization and Reprocessing) trained and have been recently appointed to create a national training project for clinicians who are EMDR trained with a speciality in working with children and adolescents.

Data Analysis

The field research for this study began on Wednesday, January 9, 2002, when the sensory motor trauma groups were initiated with the children and adolescents at the facility, and ended in June of 2003 when the last focus group was held. A total of six trauma groups–three for the adolescents and three for the children–ran for six weeks between January and May of 2002. Another six trauma groups–three for the adolescents
and three for the children—ran from October of 2002 through May of 2003. These trauma
groups ran for eight weeks to better meet the scheduling and milieu needs of the partial
program. Throughout the implementation of the curriculum, the trauma groups met on
Monday, Wednesday, and Friday each week. Each session was between 45 and 50
minutes in length.

The focus groups and key informant interviews began on March 17, 2003 and
ended on June 27, 2003. The key informant interviews were completed first; the clinical
focus groups followed. When the groups strayed from the topic at hand, I redirected them.
When they did not appear to understand the question I posed, I reformulated the question.
I took note of those questions that provoked passionate responses or controversy. By
taking notes during and immediately following the focus groups and interviews, I was
able to record nonverbal behavior such as eye movements, facial expressions, and body
shifting (Krueger, 1998).

The review of the tapes began soon after the first audio-taped session concluded
and continued through the end of June 2003. Following an individual interview or focus
group meeting, I reviewed the taped session and began the analysis process. I took notes
to indicate themes or to remember something of interest or importance, including voice
intonation and content.

Field notes were kept throughout the study. They were used to enhance my
understanding of the data and to enrich my interpretations. In the field notes, I noted the
dynamics of each group, including the cohesion and flow of the group, who assumed the
leadership role, who monopolized the discussion, which members were silent, whether or
not the group was staying on track, the meanings of the stories presented, and what was not being said.

The review of the tapes continued after all interviews were completed in order to identify themes or variances on themes and to monitor my own reaction to the process. The continued review of the tapes stimulated reflective thinking on my part.

Each of the audio tapes was transcribed. As I read the transcriptions, I became more attuned to the content and developing themes. This process, while tedious, clearly showed the dynamics and cross-interactions of the groups.

The professional staff at New Directions was consulted as the analysis progressed. They provided clarification, where necessary, and validated the process. They collectively met with me to review the data and clarify the research results. I also had numerous conversations with my advisor to check parallel process and monitor for potential counter-transference.

Summary

This study involved the collection of data regarding the perceived impact of a trauma curriculum implemented at a partial hospitalization program in Perryopolis, Pennsylvania. The perspectives of the professional staff, parents, and county specialists regarding the curriculum were investigated. Their perspectives regarding trauma were also investigated. Additionally, the views of expert practitioners in the field of trauma were obtained.

Throughout this process, I engaged in much self examination by reviewing the tapes, questioning my involvement in the overall process, listening for patterns or ways to
improve the manner in which I articulated and timed the questions, listening to my
interactions with various informants, exploring other options, and by doing much
self-reflection. I realized that the way I managed myself also had an effect on the quality
of the data I obtained.

Five focus groups, three key informant interviews, and a meeting with expert
practitioners were conducted and audio recorded. These recordings were transcribed. The
data collection began in March 2003 with a key informant interview and ended in June
2003.

The input of outside professionals who had varying interests regarding the
implementation of this curriculum offered an added dimension to this study. Field
observations, case consultations, the review of documents, and discussions with my
dissertation chair and committee members also contributed to the scope of the research.
CHAPTER IV
RESEARCH FINDINGS

Introduction

Children and adolescents in a partial hospitalization program at New Directions, located in Perryopolis, Pennsylvania, participated in a sensory motor trauma curriculum that I developed. Although the children and adolescents were not the focus of this study, their trauma-related psycho-social needs undergird the purpose of this research. When the trauma groups began, I served as the primary facilitator. The therapists participated in the trauma groups and served as co-facilitators. They were trained to facilitate trauma groups in this hands-on fashion and by processing with me following the trauma group sessions. This training occurred prior to the beginning of the study. I also conducted case consultations meetings twice each month with the therapists, the teachers and teacher aides, the student teacher, and the psychiatric nurse. We discussed clinical issues related to the trauma groups and to the overall program at New Directions.

After the trauma curriculum was in place, I conducted focus groups and key informant interviews with adults intimately associated with the program. In addition to the therapists, teachers and teacher aides, the student teacher, and the psychiatric nurse, two groups of parents, the chief administrator of the facility, a representative of the insurance company that serviced many of the children and adolescents, a representative of the Fayette County Office of Mental Health/Mental Retardation, and a group of expert practitioners were consulted regarding the trauma curriculum, its effects on the New Directions facility, and their perceptions of trauma. Additionally, I maintained a set of
field notes while conducting the interviews and took extensive notes as the audio tapes were transcribed and reviewed. I reviewed my notes many times. Additionally, I consulted with the chairperson and other members of my dissertation committee, outside readers, and colleagues, each of whom contributed in some way to the management and analysis of the data. The teachers, teacher aides, and therapists at New Directions were asked to review the transcript of the session in which they participated. I asked them to report any errors or inconsistencies they found. No such reports were made. However, two of the children’s therapists presented written statements that added richness to the information provided in the transcript of the focus group in which they participated. I also had several discussions with the medical director in which she added information that contributed to the data analysis.

The trustworthiness of this study was increased by the triangulation of the five focus groups, the three key informant interviews, and the group of expert practitioners. A second layer of triangulation was provided by the field notes I took during the process of data collection, the notes I took during the transcription process, and the information I gathered while serving as a consultant at the facility with access to client records and through conversations with the professional staff.

Focus Group and Key Informant Interview Participants

A total of six focus groups and three individual interviews were held. Each focus group and each individual interview was approximately one hour in duration, with one exception. One of the focus groups met twice and included the same individuals: teachers, teacher aides, and a student teacher. At the end of their first focus group, the
teachers, aides, and student teacher indicated that they needed to share more information; however, due to the time constraints imposed in an educational setting, they were required to proceed to regular duties. A second session was held with the group in order to complete the data collection process.

A second focus group was held with five adolescent therapists who were responsible for the therapeutic component for the adolescents in the partial program. A third focus group included the children’s therapists. One of the five children’s therapists in the third focus group also participated in the second focus group because she had transferred from the adolescent program to the children’s program and had information to share concerning both age groups. All professional staff at New Directions participated in the focus groups or key informant interviews.

Two separate focus groups were held with the parents of the children and adolescents involved in the trauma groups at New Directions. The two parent focus groups were held at different times, in different rooms at the New Directions facility, and included different participants.

The sixth focus group was held with a group of eight individuals who were not involved with New Directions. At my request, the Pittsburgh Professional Society for the Study of Trauma and Dissociation (PPSSTD), an affiliate chapter of the International Society for the Study of Dissociation, reviewed and critiqued the trauma curriculum. It is my belief that feedback from this group of seasoned clinicians who specialize in the treatment of trauma adds another perspective to this study. These dedicated individuals had advanced training in various aspects of trauma and remained current in the field of
traumatology. I had been a member of this group for 10 years at the time the curriculum was evaluated. I asked the study group to be objective and critical as they evaluated my curriculum. Because of their professionalism and dedication to the field of trauma, they critically examined the curriculum.

In addition to the six focus groups, three key informant interviews were conducted. One such interview was held with two members of the Fayette County administrative offices. Although I had intended to hold a focus group with representatives of various Fayette County offices involved in programs that affected the children and adolescents at New Directions, only two individuals were able to participate. After consulting with my dissertation committee, it was agreed to include the discussions with the two individuals due to their significant knowledge regarding the partial program, children’s mental health issues, service needs, gaps in services, and other issues. Their joint interview was considered as an individual interview rather than as a focus group. Two additional individual interviews were held with the psychiatric nurse and the administrator/medical director of the facility, a full-time psychiatrist.

All New Directions staff members were interviewed at the Perryopolis, Pennsylvania facility. I interviewed the study group during their regular June 2, 2003, meeting which was held at the Friends Meeting House, Ellsworth Avenue, Pittsburgh, Pennsylvania. Both parent focus groups were held at the New Directions facility on April 23 and June 3, 2003. The first parent focus group followed a meeting held regularly with parents after the end of the school day. I made a presentation on the effects of trauma on children and the focus group followed. The second parent group was held on Family Fun
Day between scheduled activities. The staff had agreed to this ahead of time. Because transportation is an issue for many of the parents, I attempted to hold the focus groups at their convenience. The individual interviews with the nurse and medical director were held at New Directions. I interviewed the staff from the county at their offices in downtown Uniontown, Pennsylvania.

Interview Format

I began each focus group and key informant interview in the same manner. I presented each participant with three forms: the first was a consent-to-participate in research form; the second was a consent-to-audiotape and transcribe form; and the third asked the participant for demographic information. Each participant was also asked to provide her/his name on a sign-in sheet. Participants were assured that the information was being collected for research purposes only, that the tapes would be destroyed when no longer needed for this study, and that the identities of the focus group participants would be kept confidential from all individuals except those on the research team. I verbally explained each of the forms to the subjects. All participants agreed to these conditions and signed the appropriate forms. Copies of the forms can be found in Appendix B.

The participants were instructed to request that the tape recorder be turned off at any time during the interview, should they change their minds about participating. No participant refused to participate. However, at one point an individual asked that the tape recorder be turned off to allow for expression without evidence of who made the comment. The individual expressed fear that the comment could be misinterpreted. As
the interviews were being audio-taped, I took occasional notes. Following each meeting, I made copious notations while the proceedings were fresh in my mind. Additionally, the staff at New Directions was given an opportunity to review the transcribed tapes and make any corrections or additions. This was done to validate the process.

A semi-structured format was utilized with each focus group and key informant interview. For each focus group, I developed a list of questions pertinent to the group’s roles and functions in the research process. These questions were interjected in context and to complement the flow of a session, not to interfere with the energy and flow of the group discussion. The questions prepared for each of the focus groups and key informant interviews can be found in Appendix D.

Because of the synergistic nature of the groups, many of the questions on my list were answered without prompting. I acted as an observer rather than as a participant as much as was possible in order to capture the perspectives of the participants regarding trauma and the curriculum implemented within the partial hospital setting.

Findings

The reports of the various focus groups and key informant interviews are described below. Each report is followed by a discussion of the themes that emerged from the session being described. To prepare the reader for the discussions that follow, Table 1 identifies, by name only, the various themes that emerged from one or more of the focus groups or key informant interviews. In Table 1 and each of the tables that follow, the themes are listed in alphabetical order and not in the order in which the themes emerged or may have been of relevance to the group being discussed. Following the report of each
focus group or key informant interview, the emerging themes are discussed and summarized in a table. At the end of this chapter, a cross-case analysis and discussion are provided; the results are again summarized in a table.

Table 1

*Emerging Themes from Focus Groups and Key Informant Interviews*

<table>
<thead>
<tr>
<th>Emerging Themes</th>
<th>Additional Interventions</th>
<th>Application of Interventions</th>
<th>Behavior Problems</th>
<th>Boundaries</th>
<th>Client Growth</th>
<th>Clinical Experience</th>
<th>Clinical Growth</th>
<th>Closure</th>
<th>Cohesion</th>
<th>Communication</th>
<th>Counter-transference</th>
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*Focus Groups*

*Focus Group with Teachers, Teacher Aides, and Student Teacher*

The setting. As I entered what was now a familiar environment, I contemplated what might unfold as I met with the teachers, teacher aides, and student teacher at the
New Directions site. I had gotten to know these individuals through the twice-monthly staff-case consultations held for approximately 18 months prior to the research. From my perspective, the staff-case consultations were significant and contributed to the research for several reasons. First, clinicians, teachers, aides, and the nurse met in the same room to review concerns with particular students. They interacted as a team during these open discussions, discussed differences and similarities, and offered feedback to each other. I as a consultant to the group, offered clinical direction and system collaboration with education, mental health, children and youth, legal, parents, and ancillary services. Second, these clinical meetings gave the participants an opportunity to become familiar with me and feel comfortable about expressing with her their concerns, observations, and frustrations. Third, these meetings also provided information that helped me in shaping this research.

While the teachers and aides were not active participants in the trauma group sessions held with the students, they certainly were key players. Following the trauma groups, the students proceeded to their next academic class. Sometimes, the teachers had to deal with repercussions resulting from the sessions that affected the students’ behaviors either externally–defiance, crying, name-calling, and other acting-out behaviors–or internally–withdrawal, detachment, and other similar behaviors. Because of my role as a consultant, I was aware that the teachers and teacher aides were very observant and reliable reporters. They would also offer a perspective different from that of the clinicians.
First session. The focus group with the teachers, teacher aides, and student teacher was held in one of the classrooms. As I entered the room, the group was just gathering. They sat around a semicircular table, a new addition for each of the three classrooms at New Directions. The table allowed the teacher to be “in the center” with each student equally distant from her as they did academic group work. The students also had traditional desks in another area in the room. Also, in the room were several work stations, a computer, the teacher’s desk, books, and a television. Along one of the two long walls were windows, three-quarters of the wall height. The other long wall held the chalkboard and doorway. The classroom was bright and welcoming. The room was sunny, and there was no need for lights.

The group was chattering and laughing about the day and discussing plans for the evening. As they sat around the table, I distributed the consent forms and information sheets and described the procedure we would follow. I also thanked them for participating in the study.

I began the focus group by asking for their reactions regarding the implementation of the trauma group curriculum. A teacher immediately responded stating that I (the researcher) probably would not want to hear what she had to say. I encouraged her to express her concerns. She said that the teachers had not been included in the process because they had no idea which students were involved in the trauma groups. Another teacher added that the students were taken from the rooms during the first class period when the trauma groups were initiated one year earlier. In that way, the teachers could identify the students who were participating in the trauma groups. However, when that
procedure was changed administratively, the teachers had no way of directly identifying
the students who participated in the trauma groups. (After an administrative change, the
students were randomly assigned by the clinical staff for inclusion in specialized groups,
including the trauma groups, and went directly to the groups. The students were not called
out of class.) Several other teachers added that they were not informed as to who would
be attending the trauma groups. One teacher said: “We’re out of the loop.”

This appeared to be an important issue with the members of this focus group.
Another teacher remarked: “We can guess by their behaviors. My clue is behaviors.” One
teacher stated that she could not determine who was in the trauma group simply by the
behavior they exhibited. While they were apologetic for addressing this particular issue,
they also wanted to be informed concerning the students in the trauma groups. I
acknowledged their comments and asked how the “problem” could be solved. The group
agreed that a list would be helpful and I accepted responsibility for producing such a list.

At one point in this discussion, the student teacher spoke up regarding the trauma
curriculum, indicating she did not know what it involved. I then provided a brief synopsis
of the curriculum. The student teacher then asked “What is trauma?” and, in the same
sentence, offered her definition, “physical and sexual abuse.” The others in the focus
group and I identified other kinds of trauma such as the sudden death of a relative or close
friend, surviving or witnessing a house fire, experiencing neglect, witnessing violence
and murder, and watching reports of war on the television.

Once the student teacher’s question had been satisfactorily addressed, I returned to
the previous discussion and asked how the teachers could be included in the process. One
teacher suggested that I meet with them midway through the trauma groups in order to review how the children were doing in the groups. Complaining that there was a communication break between the teachers and me as the researcher, the same teacher put it this way: “I mean right now you’re working in a vacuum as far as we’re concerned or we’re working in a vacuum. One or the other, we have no idea what you’re doing.” She then added that “the therapists know because they’re included in the groups.”

I then asked if they had a copy of the curriculum. (Several copies were available in the front office.) They indicated, somewhat loudly, that they had not received a copy of the trauma curriculum. After assuring them that they would be given copies of the curriculum, I continued with the focus group. It was obvious that they were not ready to continue with another subject because they directed the discussion back to the structural change: “We knew who was in the group ‘cause they were taking them out of class, and we fairly well . . . could watch them. We knew to be kind of careful. You know, we knew that they were . . . vulnerable.” There was agreement on the use of the word “vulnerable.” The teacher who had spoken went on to say: “. . . we kinda’ kept an eye out and maybe were a little more . . .” But, she was interrupted as another teacher interjected: “We still didn’t know anything that was going on.” Several teachers reiterated that what they knew was whether or not a student was a member of a trauma group. They also indicated that they had no knowledge of what occurred in the trauma groups: “We still didn’t know anything that was going on.” This theme continued until I again guaranteed that the teachers would be given a list of trauma group participants and then asked one of the structured questions in order to redirect the group.
When asked what they noticed in the classroom after the students returned from the trauma group, the group responded by laughing. However, they agreed there was “spill over” from the trauma group sessions.

They then began to compare which classroom exhibited the more aggressive behaviors after a trauma group session. One teacher reported handling the students’ return this way: “I don’t know if . . . we are not as sympathetic towards that ‘cause . . . I don’t want to hear what you [the returning student] have to say. . . . You are here to do math right now. . . . I don’t have time right now to listen to you. We have nine other kids and we have to get through this lesson. I have to structure it.” The same teacher went on to compare her room with the other two rooms in the school: “We don’t, by all means, have the best class in the world, but we don’t let them get out of their seats. We are on them to sit down. Do you know what I mean? . . . It just doesn’t seem that they act out any of their emotions compared to your two rooms.” One of the other teachers defended her approach: “We are more on task than off task in the classroom. . . . It’s just when certain people are in the room, . . . certain people feed into children’s behaviors.”

An aide for the children stated, “We see hyper-goofy hyper-goofy [behavior] . . . and we will say ‘must have been in trauma.’” The aide went on: “If they’re angry or real withdrawn, we’ll know not to take $25 off of them. (A token economy is used with the children. They are rewarded for good behavior and they lose points–dollars–if there is a problem with their behavior. The money can be spent in a program-operated store.) You just go over and just pat them and try to calm them down and try to get them to get to their task. And, usually it works, but sometimes it doesn’t.” A teacher added: “But, if
someone intervenes before we do and takes all their money, you have nothing to work with. And, then you have the outbursts.”

The next question addressed the behavior of the students on Tuesdays and Thursdays, days on which there is no trauma group. The day on which the focus group was held was a Monday, and there had been a trauma group that day. Interestingly, two of the teachers responded with: “Did trauma group happen today?” and “Didn’t even know we had trauma group today.”

One group member stated that the children’s coordinator was not on-site on Wednesdays. She had assumed things were “thrown off” that day because the coordinator was not there. Then she added: “That makes more sense. Wednesdays are horrible.” The teachers indicated that they had certain children “pegged” on Wednesdays, saying they were “awful when we come in” [on Wednesday mornings].

Several individuals pressed for the names of specific children. I unknowingly identified the child to whom the teachers were referring and commented that the child did well in the trauma group sessions. This precipitated responses of disbelief from the focus group members. Then, one of the teachers said of the child’s behavior: “It’s been much better in the past few weeks. Much better.” A second teacher agreed: “Yes, indeed.” Relating a specific incident, one of the teachers said: “The behavior has really changed.” She indicated that she had been in another area when she heard commotion in her classroom. “They [the children] were carrying on in my room, and he got up away from the mess and walked to the other side of the room.” She added: “He’s done that twice
now.” Several others in the focus group agreed that the child under discussion was trying to not get into trouble.

This led to a discussion of specific children. Although I attempted to redirect the conversation several times, it became clear that this group related to the curriculum by what they witnessed and experienced with specific students. Their comments communicated their concerns for their students: “R is so quiet, as quiet as can be.” “I didn’t think she was in trauma. She’s like that all the time. She’s too quiet.” “Lots of them can’t take direction.” One teacher began: “She sits in the bus room . . .” and another continued: “and never makes a move. She sits there and colors. She will do anything for a sticker.” Of a particularly challenging child, one teacher says: “He takes all I can muster. He will do absolutely . . . anything for me. He comes in every morning just wilder than . . . I can get to him; he will calm immediately. They [the therapists] yell at him. . . . They’re gonna’ call his PO [probation officer]. . . . And, I mean this is every morning! All that does is get him more and more agitated. . . . That really bothers me.” She went on to explain that “it’s a half hour or forty-five minutes before he gets to me. . . . You can hear him coming down the hall.” It was clear from her discourse that, at times, the teachers were unable to be heard by the therapists, particularly when they discovered something about a student that was helpful. The teacher who had been talking indicated that her attempts to speak to the therapists about the child yielded the response, “. . . basically what I get is that I baby him.” Another teacher supports her colleague: “It’s the same way at home. They just came from that situation. So, we’re just duplicating what they came from.” Discussion follows about a second child who often came to school in a
rage. They noted that by gently calling his name, he calmed down almost immediately and did not always seem aware that he was so upset.

When asked if they had noticed any changes in their perceptions or understanding of disruptive behavior in the classroom, particularly regarding trauma, one teacher says: “I try not to add to their abuse.” Several of her colleagues agree. Another teacher added: “Not that they don’t get redirected, but like . . . was saying, not to the berating. There is a way of doing it. It’s not that we let them do what they please. But, to redirect them in such a fashion that you haven’t damaged [them].” The first teacher adds: “. . . that it’s not degrading.”

The teachers discussed positive, rather than negative, approaches used to “reach” their students. When they tell their students “I know you can do it,” the students often respond with “No, I can’t do it.” “You can hear the negativity that’s been instilled in them.” They then discussed different approaches that could be taken to assure student success: “But, you can do it. Prove it to yourself.” “Maybe instead of the 15 problems you have to do in math, you can do the seven. That is all you have to do today.” “You can always individualize it.”

When asked again to comment on the behavior of the students on Mondays, Wednesdays, and Fridays (trauma group days) versus Tuesdays and Thursdays, the group broke into laughter. This was followed by silence. Commenting on one particular student, a teacher said: “he was good for me all last week and Tuesday all heck broke lose.” Another says of the students: “Most of these kids don’t sleep well at all.” Another adds:
“They often don’t look rested.” The first teacher says of one student: “Well, you know there are times . . . has been sleeping in a car.”

There were issues that needed to be further addressed. Unfortunately, the teachers had to leave for their bus room duty. They agreed to meet again on April 28 at the same time.

Second session. The second session was attended by all the participants in the first session. I immediately began the session by discussing the communication issue raised in the first session. Because it was important for the teachers to know who was in which trauma group, I requested that the coordinators give teachers the names of the participants at the beginning of each segment of the trauma groups. The teachers also reported they now had a copy of the curriculum.

They immediately began discussing one of the adolescents in the trauma groups, noting changes in his behavior and attributing those changes to his participation in the trauma groups. The teachers reported that he had been in a fight in the classroom and was crying after the incident. The teacher quietly calmed him without calling attention to him in front of his peers. It was after that incident that the teachers recognized a change in his behavior. Two teachers described him as both “likeable” and a “pain in the butt.” Another teacher commented that she cannot motivate him during her first period class; all he wants to do is sleep.

I asked if the teachers and aides had seen this particular student’s “safe place project.” One teacher referred to it as “the cardboard,” another knew it included “army men.” The first teacher went to retrieve the project. The project included many animals,
covered wagon, an emergency vehicle, trees, and a fence bordering the entire project.

Discussion of the project prompted questions about the environment in which the adolescent lived. One teacher reported that “this morning he was pretty good.” She went on to say that “he likes to be busy; he likes to do things with his hands all the time.” Another teacher agreed and listed several of the tasks for which he volunteers–washing the board and emptying the trash can.

The teachers continued to discuss various students, all of whom participated in the trauma groups. They were able to identify changes in the children. One child, who had previously crawled on the floors “like a snake,” was participating and doing well, particularly when he was writing. The teachers said he would do almost anything for a pen. He even gave his teacher a note in which he commented on another student who had been disrespectful to the teacher. Believing that the disrespectful student’s mother should be informed of his behavior, the student who liked pens provided the telephone number for the other student’s mother. Although the student who liked pens needed to be restrained occasionally, the teachers reported seeing progress in several areas. They also noticed he shook considerably when he wrote. When I suggested some exercises to ameliorate the problem, several of the teachers said they would have him perform the exercises immediately before beginning his writing assignment.

The discussion then focused on a female child who ate very little–only one-half of a peanut butter sandwich at lunchtime. Previously, the family had packed her lunch, including four different food items. When the family no longer packed the lunch, it
appeared to make a difference for the child. However, when she had the help of a tutor, her academics improved. Without warning, the tutoring stopped and her work declined.

There was agreement among the teachers that the trauma curriculum and trauma groups were appropriate for the partial program. They teachers provided an explanation of the manner in which the groups were originally configured and the manner in which they were configured at the time of the focus group. Initially, the therapists assigned the students to specific trauma groups. The trauma groups were held during the first academic period of the day, and the teachers knew which students were in the trauma groups. Later, a program change was made. All students in the school were assigned to a group, either one of the trauma groups or another general group that dealt with one of several areas. These groups met for eight weeks. When the adolescents assigned to the trauma group met with me and their clinicians, other adolescents in the school were in class. However, when the children assigned to the trauma groups met with me and the clinicians, the other children in the school attended one of the other groups. Therefore, the teachers did not know which group the children were attending. This was the basis of their complaints.

At the end of the focus group, the teachers said they wanted to know if a child or adolescent had a difficult time in the trauma group. They said they wanted to be informed in order to help the children.

**Emerging Themes**

Eighteen themes emerged from the two-part focus group held with the teachers at New Directions. The themes to emerge were application of interventions, behavior
problems, boundaries, client growth, clinical growth, communication, counter-transference, development, diagnosis/symptoms, empathy, environment/structure, exclusion, organization, poverty, process, resistance, safety, and support for trauma groups. Table 2 contains a list of these themes and is followed by a discussion of the themes.

Table 2

*Emerging Themes from Focus Group with Teachers, Teacher Aides, and Student Teacher*

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<tr>
<th>Emerging Themes</th>
<th>Counter-transference</th>
<th>Application of Interventions</th>
<th>Behavior Problems</th>
<th>Development</th>
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<td>Boundaries</td>
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<td>Communication</td>
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*Application of interventions.* The next emergent theme was application of interventions. This theme was documented by only one teacher in the first session and in reference to young children. She said she had seen one student perform an exercise from the trauma groups.

*Behavior problems.* The teachers were concerned about behavior problems on the part of the children and adolescents. They documented several problems including emotional outbursts, inattentiveness, tearfulness, and restlessness.
**Boundaries.** The teachers had established certain physical and emotional boundaries which could not be crossed by the students in their classrooms. These included the children not leaving their seats, not yelling, and not throwing things in the classroom.

**Client growth.** Another emerging theme was client growth. While the teachers identified students with “problems,” they also discussed the emotional and behavioral growth, or lack thereof, of their students.

**Clinical growth.** This theme was also evidenced in the focus group. The teachers asked for direction from me and the clinical staff at New Directions so that they could help their students with affect management and self-esteem in addition to the academic support they typically provided to their students.

**Communication.** The teachers said they needed to be given the names of those students who were participating in the trauma groups each time a series of trauma groups began. They also wanted to be informed about the activities that occurred in the trauma groups. A third communication they requested was information concerning any student who may have had difficulties or was upset in the trauma group prior to entering their classrooms.

**Counter-transference.** The next theme, counter-transference, was identified by teacher behavior in which they referred to their reactions to a child. Without knowing for certain that a child had been in a trauma group, they reported that a child had been in the trauma group if the child misbehaved. One teacher identified peculiar behavior on the part of a particular student and said he had done it just to upset her.
Development. Development, specifically the developmental level of their students, was another theme discussed by the teachers. They cited many instances in which the students were not able to function and perform at the level appropriate for their chronological age group.

Diagnosis/symptoms. The next theme was that of diagnosis and symptoms. The teachers reported certain behaviors on the part of specific children. Over time, they found these behaviors to be predictable, repetitive, and ongoing. The teachers identified them as attention problems, aggressive acting out, yelling, consistent expressions of low self-esteem, and extreme fatigue.

Empathy. The next emerging theme was empathy. They were concerned with the well-being of their students and did not want to respond in a way that would aggravate the child. Several teachers indicated that their students were “yelled at” repeatedly and said they didn’t want to add to that or degrade the students.

Environment/structure. The teachers had several comment regarding the environment or structure of the New Directions program. They also indicated that they are often not heard when identifying concerns regarding a child or when making suggestions regarding interventions that help a child. They also made comments regarding the organization and structure of their classes. For example, one teacher commented that when she recognizes that a child is overwhelmed by an assignment, she will immediately modify the assignment for that child on that day.
Exclusion. The teachers reported being “out of the loop,” thus leading to the identification of the next theme. They reported not knowing what occurred with the trauma groups and said they were working “in a vacuum.”

Organization. The teachers addressed that the organization should be providing feedback to the teachers. Although copies of the curriculum had been placed in the main office for all staff members, the teachers wanted to receive a copy.

Poverty. Although poverty was not an overwhelming theme to emerge from the teacher’s focus group, one teacher alluded to it. In discussing one of the students, a teacher commented that he lived in a car some of the time.

Process. The process used by the teachers was, in great part, intuitive. They did not describe the specific behavior of a child. Rather, they gave detailed explanations of what the child had done and the manner in which the child had accomplished the task. The process they used in discussing student behavior was to give example after example. Instead of identifying a child as “developmentally delayed,” the teachers gave examples of the child’s behavior—a second grade student drew on the level of a four-year-old, he breaks pencils, he breaks off erasers, he likes crayons, his writing is shaky.

Resistance. Several teachers concurred that when they encourage their students “I know you can do it,” the students often respond with “No, I can’t do it.” The teachers commented, “You can hear the negativity that’s been instilled in them.”

Safety. In the area of safety, the teachers wanted to know what to do in order to keep their students and classrooms safe. It was evident they were concerned about their students.
Support for trauma groups. The teachers offered support for continuing the trauma groups. Offering that they had seen improvements in certain children, the teachers attributed the progress to involvement in the trauma groups and endorsed their continuation.

*Focus Group with Adolescents’ Therapists*

*The setting.* Four therapists—two males and two females—worked with the adolescents at New Directions. I met with the four adolescent therapists in a classroom at the New Directions facility. A fifth therapist participated for most of the focus group. She co-led one section of the adolescent trauma groups but later transferred to the children’s unit. She was the only therapist trained for both the children’s and adolescents’ trauma groups at New Directions. When I entered the room, I found the five individuals scattered around the room.

The room did not serve as a classroom; rather, it was used for other activities. It held a long table with folding metal chairs. There were metal shelving units along one long wall in the room below the windows. Along one-half of the other long wall and one of the shorter walls were different kinds of boxed, canned, and bottled foods that were provided to families by the staff. On the other short wall was a window. Adjacent to that was the staff restroom, which was not used when the room was being used for some activity. The room was rather gloomy.

I informed the participants that the focus group was being held for research purposes and reviewed the consent forms. The therapists acknowledged that the focus group would be audiotaped.
The session. I began the session by asking if the therapists could talk about their experiences in working with the trauma groups. The focus group members were responsive to the question. Three therapists who had rotated through the trauma groups with me agreed that the group “provided a safe environment for the adolescents.” This safe environment was reinforced when the therapists addressed only those issues the students brought to the group: “They were not forced to discuss or disclose anything that they did not want to.” One therapist reported that the students were even learning “terms or labels for what they were feeling.” Placing labels on their conditions and discussing them with the others in the trauma group validated the students’ experiences, particularly when they realized that others had similar experiences or symptoms. They came to realize that many of their responses were a result of the situations they had survived. One therapist reported comments such as “I have nightmares like that” and “I get really nervous and my legs get really tingly,” a description of their somatic experiences. Additionally, the therapists presented that the “warm up exercises [Brain Gym®] provided consistency and helped relax, center, and focus the participants.”

On the other hand, the trauma sessions awakened many feelings for the students. One therapist put it this way: “A lot of behavior problems came out of trauma too.” The adolescents also demonstrated regression—one would go into a fetal position in response to a flashback, some became more defiant, while others would use inappropriate language in the hallway following group. “The kids were unable to deal with all that was coming up for them.” Even though the therapists witnessed and reported negative behaviors, they “saw them [the students] cope and deal and feel safe and deal with some of the unpleasant
feelings . . . They were able to do that in a way that . . . de-escalated in time and, actually, in the end, they were a lot better off.” The regressed behaviors were reported as intermittent rather than constant: “It was on and off and then it just left again.”

Two clear examples were provided by the clinicians in which strong emotions surfaced due to the activities conducted in the trauma group. One involved a young man in the first adolescent group. It was his day to present a song that was significant for him. The group was attentive and, as the music played, he became very still and withdrawn. He began to rock back and forth. [When that occurred, I recognized that he was dissociating, stopped the process, and attempted to ground him.] At the same time, his peers were appropriately concerned and did not know what was happening. It took some time to get the student grounded. Understandably, he did not want to discuss what had occurred. He chose to not process the incident in the following group, rather, he discussed what had happened with his therapist in a one-on-one session. According to the therapist, “The song reminded him of a time he went home to talk to his mom as he felt badly and she was not there.” He reported that his mother was unavailable to him emotionally. The song was a trigger for him.

The second example involved a female adolescent who was repeatedly abused—sexually, physically, and emotionally—by her mother and the mother’s paramour. This student had been restrained many times when her behavior warranted it and consumed much of the staff’s time. Many things triggered her. Her peers avoided her. She had a difficult time staying focused during the first few weeks in the trauma group sessions. Then, she began to use the exercises. She also repeated the trauma group two
additional times. One therapist related, “The result is well worth it. We have a young lady who is 100% better than what she was a year ago. While she won’t leave the program anytime soon, she is 100% better.”

I asked the focus group members if their understanding of trauma had changed as a result of working with the students in the trauma group. The therapists unanimously responded in the affirmative and initiated a discussion on their notion of trauma. They identified it as related to abuse, but they also included fires, accidents, death, “even living in certain places,” as traumatic. When I shared that Fayette County [in Pennsylvania] has one of the highest levels of poverty, a risk factor for trauma, they acknowledged with “right behind Philadelphia in all the wrong things.”

Two of the therapists indicated that trauma has been discussed in one of their master level courses. Another individual remarked that he or she used the “learn by experience” model. I “learned it here. That’s where I’ve learned most of it.” Yet, another therapist remarked: “I have been doing this for nearly 10 years, and trauma still is an area I don’t know as much as I should. . . . I was never oriented or trained in it in my training or the early part of my career, and, then, we went through the period where there was a big controversy about repressed memory and all that good stuff and it clouded the picture even more . . . I personally viewed it as something akin to voodoo, and I no longer do. People used to talk about trauma work, and I thought ‘Why don’t they just bleed them with leeches?’ I was wrong. I was dead wrong.” This therapist then said of the methodology used in the trauma groups: “It works A number one in spite of my sarcasm.”
I then asked the focus group members what they had learned or discovered while participating in the trauma groups. One therapist began: “It takes a lot of understanding from staff of what’s going on in the groups and what happens as far as getting stirred up. I think we are invested in trauma.” Another added that, as a staff person, one learns to “delay gratification” because, after conducting a single group intervention or an individual session, the therapist cannot “expect that it is going to take effect immediately. You have to wait that year.” Yet, the therapist went on: “When they did that exercise . . . [in which] they tore a picture from a magazine that symbolized something that they wanted gone which was symbolic of their trauma, . . . I could now see how [trauma impacted an individual]. . . . You can talk about delayed gratification, but [the work done in these trauma groups] planted those seeds of healing.”

A clinician new to the field commented that he or she always believed that clients have “hidden stuff.” Due to her/his participation in the trauma groups, he or she also acknowledged the importance of not forcing the adolescents to reveal the hidden stuff: “I’ve realized by being in the groups that not having the pressure to talk about it was crucial. You don’t want to talk about it? Well, that is OK. But, in the trauma group they were working on it on many different levels.” The therapist went on to say that it was “fascinating” to watch the process whereby adolescents who refused to open up to the group concerning their “issues” make a complete turnaround and begin discussing their experiences.

I then asked the therapists what they noticed about the process of the adolescent groups. Adolescents were selected by the adolescent clinical staff for inclusion in the
trauma groups. Males and females were included in the same group. One therapist offered this: The adolescents “worry about what their peers will think of them. I think they are more open in their own individual groups than they are in the mix. They do not know each other well enough to know if they can trust this person, are they going to blab it, or are they going to make fun of me?” Another clinician added: “We see that in all of our specialized groups, we always get more disclosure individually than in any of our specialized groups. . . . those dynamics are in all of our specialized groups.” However, one of the therapists described her/his experience this way: “They [the adolescents] did not seem to be concerned about what others thought. If someone was quiet in the beginning, they would . . . gently encourage them to talk.” A member of the focus group who had remained rather quiet offered the following regarding the trauma groups: “I think that the nature and the topic of the group is very personal. And they [the adolescents] were able to overcome that.”

The therapists said that, initially, the adolescent trauma group was “frustrating, as we threw the group at them and handpicked the teens we knew had a trauma history.” Another added: “They [the adolescents] were uncertain of it.” I acknowledged that because the first section of adolescents took some time to focus, the group had to continue for three additional weeks after the six weeks that had been allotted. One of the

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1 Generally, the adolescents are members of a fairly permanent section for most of their activities. However, adolescents are taken from each of those sections and “mixed” together for the trauma group.

2 Some of the “specialized” groups alluded to by this clinician address topics such as self-esteem, family issues, relationships, and dating.
therapists in that specific section said with a tense voice, placing emphasis on her/his words, that “it was tough . . . . It was really difficult [dealing with the resistence] because they thought we were picking on them and one of their favorite staff persons left.” The clinician went on to say that her/his leaving also contributed to a major disruption for the adolescents. The ramifications of her/his departure lasted several weeks because the students focused their discussion on that event, rather than on their own traumas. The therapist added that she had to continue to lead the group herself for the next three weeks until the adolescents finished the trauma curriculum. Another member added that the adolescents now consider trauma groups as “routine” and added “that is good.” The groups had come to be so accepted that the clinicians reported requests from two adolescents to join the trauma group.

One clinician expressed frustration: “It was probably me, not the activity or the impact it has. The Safe Community [project] became chaotic for me. I think that they become so involved with the little figurines that they don’t get involved in doing the safe community, they want to play. . . . The adolescents, it didn’t seem like that they would let go enough to do it as it was meant to [be done] . . . . It’s just me ‘cause I get so annoyed . . . they use what they have, instead of using what happened to them, to make the community safe. They use what they have to make the safe community–they use army men, trees, and the [craft] stuff to make the communities, rather than [thinking] ‘I would have been safe if . . . ’.” Another therapist remarked that “the most we ever got out of the adolescent group was throwing that ball, the target.” Another added: “Half of them like the group, and the other half see it as a chore.”
The other therapists did not agree with these statements. One offered: “four or five of the clients in the group expressed that they did not have a childhood, meaning that they had little time for fun things, and had a paucity of resources—toys, games, activities. It was phenomenal, they all talked, they all participated, which is a victory in and of itself. . . . I will never forget, it was one of the most mature discussions we had, . . . it was the commonality [about] which they talked.” Another therapist stated, “[While] doing the Safe Environment Project, one client in particular was driving me nuts because he had his tongue hanging out the whole time. But then I realized he was not even aware of it. He was so into what he was doing.” Another clinician new to the program offered: “One of the males repeatedly stated he was getting nothing out of the group; on the other hand, he was working hard on the Safe Environment and was irritated that his project kept getting damaged in some way, and he addressed that frequently. His process made me think maybe this is affecting this kid, and it may need more time. . . . This is an eight-week group; maybe it should be longer.”

I asked the clinicians if they were aware of any instances when the adolescents transferred the trauma group exercises to other areas within or outside the New Directions program. One therapist said that, from being in other groups with the kids “those who have been in trauma groups know what trauma is, know what a flashback is, know what grounding is. That is pretty impressive. I have seen them help each other. . . . For example, today in group two girls brought up something about sex. The other client started to shake. One of the kids said ‘What do you do when this happens?’ and they
pretty much looked at me. They started giving her cues: ‘Grab onto your chair,’ whatever it took to get her grounded, and it was pretty much successful.”

Others in the focus group responded in agreement: “Some of them will suggest to their peers that they do the Pretzel.” “Even five years from now, we’ll be doing ‘Duckies and Bunnies Therapy.’ They will still be doing the Pretzel.” The rest of the group laughed in agreement. Another therapist who also does a relaxation group reported that she will look around and notices that everybody is her group, doing the Pretzel. “Some of them think of trauma and are able to relax.” She continued: “The relaxation group has been here for forever, and if one-fourth did the exercises outside of the group, I would be thrilled to have those high of numbers.” Another group member recalled an incident in which a male client was acting aggressively. Another staff member had intervened in order to prevent a physical altercation. The male client later reported that “deep breathing helped him, and if it weren’t for that, he did not know what he would have done.”

When asked what they would keep, add, or delete with respect to the trauma group curriculum, the therapists had several suggestions: “The structure was such that whatever came up was what was worked with. It wasn’t targeted . . . it was not totally therapist-directed. They [the students] did the work. . . . They were validated by hearing what other members said. . . . [With] the warmup exercises, there was some consistency, and they [the warmup exercises] helped to relax them and center them.” Another offered: “It gave them [the students] an opportunity to open up and to share things. . . . And, knowing and learning that their peers went through similar things helped them to talk and be more open.”
“They really like the inside-outside box a lot. We learned a lot about some of the kids. . . . They did really good. I really liked them [the inside-outside boxes].” A therapist with many years of experience at New Direction stated that he had not seen anything that should be removed from the curriculum. The therapist who co-led the first round of adolescent groups suggested the “need to do the music differently.” All of the clinicians agreed that the target practice exercise was an effective intervention and touched on the emotional aspect of trauma for the students.

One of the focus group members asked me about the “whole body sculpture” exercise which had been offered to the adolescent trauma groups as a choice but never selected by the participating teens. [A detailed description of this exercise is titled “Self Portrait” and can be found in Chapter III.] One individual asked: “Can we make them do that? Because, if they have a choice, it’s probably too close to home, more so than the inside-outside box, and they will not select it.” This was followed with: “It might make a difference if it is explained differently or an example is shown to them. They may not be certain about what is entailed.” I welcomed this feedback and restated that providing a survivor with choices is important. It is also important, developmentally, to offer choices to the adolescent population. I reassured the therapists and encouraged them to promote the sculpture exercise with the adolescents.

One therapist felt that the concept of not having a childhood needed to be part of the curriculum, and I invited brainstorming concerning this concept. The therapist said it would fit in the middle of the curriculum so that group cohesion could be well-established prior to the introduction of the activity. The therapist envisioned a box
containing dolls, trucks, stuffed animals, and other toys. He believed that family roles would surface while doing a form of play therapy. He felt role play would be less threatening to the clients through the use of dolls and animals. He had also indicated he would like to include a sand tray due to “the sensory aspect of running fingers through the sand as a soothing technique.” I encouraged further brainstorming ideas as a way of making future changes in the curriculum. I also stressed that timing and pacing were both essential considerations that should be considered. She stated that there should be purpose and intent in the implementation of any exercise. No activity should be used if its purpose is to simply “do something.” The therapist who had spoken a few minutes earlier disclosed creating a group intervention he called “The Cognitive Triangle.” It came about as a result of his participation in the trauma groups and of the “multi-sensory, multi-modal approach” used in the trauma groups. “I don’t think I would have had that spontaneity and creativity of the activity had I not been in trauma” he added.

This lead to another question, “Have you thought of yourselves as being part of and having a piece in developing the curriculum here?” One therapist mentioned liking the Mind Mapping activity. I reminded the group that the activity came from one of the therapists as a suggestion to increase cohesion in the group and to get the students focused on the issue of trauma. When the focus group members failed to respond, I prompted them about the Role Play exercise they implemented. The group members then nodded recognition of their input in the curriculum.
Emerging Themes

A total of 23 themes emerged from the focus group with the therapists for the adolescents at New Directions. Those themes were additional interventions, application of interventions, behavior problems, client growth, clinical growth, cohesion, counter-transference, culture, development, diagnosis/symptom, disclosure, empathy, environment/structure, lack of training, organization, poverty, process, repeat of the trauma groups, resistance, safety, sensory, support for trauma groups, and theoretical orientation. A list of these themes can be found in Table 3, which is followed by a discussion of these emerging themes.

Table 3

**Emerging Themes from Focus Group with Adolescents’ Therapists**

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**Additional interventions.** Outside of the trauma groups, some adolescents tried to help their peers to manage affect. They were also seen to show peers not participating in the trauma groups how to do the Pretzel.

**Application of interventions.** One therapist talked about an intervention he wanted to introduce in the middle of the group. In the suggested exercise, the adolescents would work with various toys from childhood.

**Behavior problems.** The adolescents’ therapists reported regressed behavior following some of the trauma group sessions. For example, when experiencing a flashback, one student went into the fetal position; other adolescents used inappropriate language in the halls following the groups. The therapists reported that the adolescents did not know how to deal with what they were experiencing.

**Client growth.** The therapists reported that the adolescents learned new terms for what they were feeling. “We have a [young] lady who is 100% better than what she was a year ago.” They noted that behavior initially escalated then “de-escalated in time” and “in the end they [the adolescents] were better off.”

**Clinical growth.** This emerging theme was exemplified by one particular statement made in the focus group: “I personally viewed it [trauma] as something akin to voodoo, and I no longer do.” Another therapist indicated that it takes a lot to understand the dynamics of the trauma group sessions. She continued: “You can’t do a single group intervention and expect that it is going to take effect.”
**Cohesion.** The therapists noted that cohesion developed among the adolescents when they learned that their peers went through similar experiences. They were given the opportunity to share things with others who had similar experiences.

**Counter-transference.** A statement by one of the adolescent therapists exemplified this theme: “I think that adolescents use that [resistance] as an excuse to act out.” Another said: “It gave them a reason to go at each other one day last year.” Another therapist made an assumption when stating: “It’s the kids’ group . . . that’s why the kids felt more comfortable.”

**Culture.** The therapists agreed that the trauma groups had become part of the culture of New Directions. One stated that in five years, they would still be doing “Duckies and Bunnies Therapy” and the Pretzel.

**Development.** The therapists reported that some of the adolescents “felt” they had no childhood because they had few memories to recall and could not remember playing. One therapist sensed that when some of the adolescents made their safe environment project, they “just played with the little figurines” and did not get into what it was supposed to represent.

**Diagnosis/symptom.** The therapists related an incident that occurred during the regular school day with a trauma group adolescent. The adolescent became aggressive with the staff, could not be redirected, and needed to be restrained. The adolescent later recalled that the restraining process was reminiscent of past abuse from the mother’s paramour. The therapists also reported that another adolescent dissociated to music the adolescent had chosen to share with the trauma group. While the selection was neutral, it
had significance for the adolescent and triggered emotionally painful times with the parent.

**Disclosure.** A clinician new to the program offered: “One of the males repeatedly stated he was getting nothing out of the group.” An observation was made regarding the adolescent group process pertaining to disclosure: “. . . adolescents who refused to open-up to the group concerning their issues made a complete turnaround and began discussing their experiences.”

**Empathy.** This theme was expressed by one therapist who remarked that it takes a lot of understanding from staff to deal with the adolescents and went on to discuss what “stirred up” the clients. The staff indicated that they realized that some of the adolescents struggled, but they commented that the adolescents “came through it.”

**Environment/structure.** The therapists noted a change in the adolescents’ behavior when the group moved from the classroom setting to the library. The adolescents appeared to be more focused, possibly because the room was smaller and the atmosphere of the room was warmer. The therapists also remarked that the trauma groups provided a “safe environment for the adolescents.”

**Lack of training.** In discussing their academic preparation, one therapist reported having “one course that addressed trauma.” Another therapist indicated she had learned about trauma “by experience.” A third remarked: “I only had one experience and it was bad.”
Organization. The therapists discussed the changes made in the program from one year to the next. They also stated that going through the groups as a staff person enabled them to deal with all of their clients, whether or not they had been in the trauma groups.

Poverty. The therapists discussed the impoverished conditions in which many of the students lived. They remarked that Fayette County has one of the highest levels of poverty in Pennsylvania, acknowledging it was “right behind Philadelphia in all the wrong things.” They also identified poverty as a risk factor for trauma. One therapist reported that the adolescents had indicated “that they did not have a childhood, meaning that they had little time for fun things, and had a paucity of resources–toys, games, activities.”

Process. The therapists said the adolescents were able to talk about “what things were like” or “what it felt like.” They described student involvement in the exercises as a “joining process . . . after the initial one, when they learned the exercises, it just took off.” Participating in the groups as a member of the staff enabled the therapists to deal with all of their clients, whether or not the clients had participated in the trauma groups. One therapist reflected on the process followed by one of the adolescents in the trauma group. The adolescent stated that the Safe Environment project was “stupid.” However, he continued to work on the project and completed it. The therapist reported that the same adolescent became annoyed when his project was in any way disturbed. This, the therapist said, caused him [the therapist] to realize that the project was affecting the adolescent and that the adolescent might need more time in therapy. In this instance, the client’s process affected the therapist’s way of thinking.
Repeat of trauma groups. It was reported by the therapists that the groups had come to be so accepted that two adolescents had requested to join the trauma groups. These two adolescents had taken part in the trauma groups prior to the request.

Resistance. The adolescent therapists encountered resistance during the first section of the trauma groups. The adolescents shut down, and the therapist needed to continue weekly sessions for an additional three-week period. “We just threw this [the trauma group] at them . . . they were not certain of it.” Adolescents showed resistance with comments such as: “This is dumb.” and “I don’t have any issues.”

Safety. The groups provided an environment that ensured emotional safety for the adolescents to freely discuss concerns they had. Also, the adolescents were not forced to disclose their traumas.

Sensory. A therapist addressed an intervention he or she created based on the “multi-sensory” approach taken in the trauma curriculum. Another therapist reported that one adolescent described having a “tingly feeling” in her legs after performing the exercises.

Support for trauma groups. It was stated in the focus group that the trauma groups were a “fit.” A therapist also stated they had become an important part of the New Directions program.

Theoretical orientation. Remarks were made by the therapists that addressed the theoretical orientation of the group. These remarks included “programming is cognitive-behavioral,” “[it] is not always the best modality to go after trauma issues,” “It was not therapist-directed,” and “[it] was multi-modal.”
Focus Group with Children’s Therapists

The setting. The children’s therapists met in one of the group rooms which is the size of one-half of a classroom. They clustered together in chairs with their paperwork. Because the room was bright enough from the open windows, the lights were off. The atmosphere was inviting. I opened the focus group in the same manner as she had opened the other focus groups.

The children’s therapists freely spoke of the support they offered each other both on the job and after work. They helped each other and did things not work-related. They admitted that on certain days they felt like they were working in a “war zone.” They admitted that the ability to process their feelings and reactions with each other made a positive difference in their work lives and made it easier for them to return to work each day. I reminded them that they provided an intense level of care to their clients, a level of care equivalent to inpatient treatment. She also reminded them that because their clients went home at night, the possibility of re-exposure to the ongoing chaos and traumatic situations existed.

The session. I began by asking the clinicians to share their experiences in the trauma groups. The one therapist who had transferred from the adolescents’ unit to the children’s unit spoke first, “I have been in the adolescent groups and now I’m in the children’s and feel fortunate to see the difference. The group is basically the same, but what the children grab onto is different compared to the adolescents. So, I learned a lot. It’s harder with the little kids . . . to explain things to them in an age appropriate way. I
really struggle with that, not just in trauma but in other areas too.” Two other therapists readily concurred.

Another therapist stated, “I don’t even think that they [the children] are aware of their trauma issues or what they have experienced as traumatic. They can’t understand why they are in the trauma group and understanding why they are doing what they are doing . . . I think that is especially true of how their experiences have impacted their life.”

When asked if there was anything that could be incorporated into the trauma groups to help the children in realizing they had experienced traumatic events that have impacted their lives, several therapists responded, speaking one after the other but with similar voices: “For them to realize that they are not normal.” “I don’t know how to explain trauma . . . I can’t explain normalcy.” “Normal is hard to explain to anyone. It’s just like the chaos that they go through, and it’s been a long progression from . . . generation to generation that no one in their families understands normalcy.” “Nothing in their lives is a typical kid’s atmosphere.” “Not when they are at school, not when they go home. ‘Cause we are not a regular school. We talk about a regular school, but I don’t think a lot of them understand that, especially the little ones.” There was agreement on that point: “Some have never been [in a regular school] and some have not been there long enough to understand what a school is like.” One therapist provided the example of a young female who had drawn a safe place in order to draw a picture as the other children had done. “I think she drew a picture and couldn’t connect it to anything, which is why she didn’t want to share.”
When asked what parts of the curriculum they would keep the same, the therapists had several responses. The first comment concerned the drawing of a Safe Place: “You can tell more about what they are going through as they describe something that feels safe to them than describing the actual trauma.” The Brain Gym® exercises were also identified as helpful. The therapists noted many occasions when they observed students sitting in class doing the Pretzel or Butterfly Taps. “The kids are willing to do those on their own.” Commenting that the students like and were accustomed to the structured exercises, one therapist said “You really don’t have any problem until after that’s over anyway.” This prompted understanding chuckles from the others. Another offered, “The kids take what they learn in the group to help others out of the group and not necessarily with trauma issues, it amazed me to see the kids doing the Pretzel in most areas of the program . . . the name has a reputation people outside on here, from another county, have told me about it [the Pretzel].”

The group also agreed that Target Practice was essential to the curriculum even though it was a chaotic group activity. However, they commented that a lot of energy was generated and that the activity resulted in more disclosure and the greatest amount of processing on the part of the children. “It’s safer. It’s OK for them to be angry, and it’s acceptable for them to be angry.” Another therapist stated that the activity established “cohesion” in the group: “With the target, they cheer each other on.” Moonball was also mentioned by the therapists as an intervention that was important in the curriculum. They noted that it contributed to team building, group cohesion, and group interaction. Additionally, it increased energy. The therapists noted that the children came from
different classes and that some of them did not spend much time with each other during the day outside of 45 minutes of recreation. “So, allowing them to form some kind of team with cohesion is important.”

The therapists had been given an opportunity to provide input when the curriculum was written. I asked the focus group to comment on their feelings regarding that input. “I can’t imagine what I could have done to aid in that process at all . . . I felt really blind doing that for the first time.” Unfortunately, the therapists had no additional comments regarding their input in the curriculum process.

When asked what kinds of things they would change in the curriculum, I was surprised by their response: “Definitely the environment! When you’re here, something happens before trauma group, something happens during trauma group, something happens after trauma group. There is always something going on. Something could have happened in class which they bring into the group, which totally throws the group off. . . . If this group could be more isolated from their day, or if it were longer, I don’t know. It just seems it is thrown into our day like every other thing that they do. . . . Going to trauma group doesn’t hold the importance that it should.” Another individual added: “I think it would be wonderful if it could be somewhere not in the building in the midst of all the confusion and the chaos. . . . They hear things going on in the hallway, going on in other rooms. They are more in tuned to the environment than what is going on within their own group. [It] needs to be more peaceful or calming.”

Another suggestion had to do with the time constraints relative to the trauma groups: “Forty-five minutes is a short period of time to introduce something and then
process it with a group of kids. Even in morning group, . . . you don’t always get a chance to process it . . . there’s just a short period of time to get through the activity. We need to help them talk about situations and process it so they can leave and be OK the rest of the day. I don’t know if I could do something after I talked about something terrible.” This last sentiment was reiterated by another therapist: “You’re just supposed to go on with your day and function normally and follow directions, take a spelling test, after you just talked about one of the most horrible events in your life.”

Others had suggestions regarding the students admitted into the trauma groups. One therapist put it this way: “I think if we were more selective, then things would run much smoother, and the kids who needed to be here would be, and they would get better faster. At least, that has been my impression.” Another therapist discussed the business aspects of New Directions and similar facilities: “The business concept versus therapy—sometimes it doesn’t seem to fit. I understand we are a business and that we need to take kids and, if not, then we would not exist and we would not help anybody. . . . You can’t take everybody. When we have kids here that have been horribly beaten and who have been exposed to violence, it is hard to do something this intense when you have kids who don’t mesh. I don’t think we can run a trauma group as successfully as you could do in a less chaotic environment.”

I posed the following question: “Do you have any thoughts . . . regarding what the trauma groups mean for the students?” In response to that question, several therapists voiced a common concern—that the children perceived being in the partial program as a punishment: “My group, they see it as a punishment not as a place to get help.” “When
you hear ‘I’m here because I brought a knife to school,’ and you say, ‘No, you are here because you have some mental health issues that we want to help you with.’ “We are here to teach you new coping skills. You are not here because you beat somebody up.” The therapists also indicated that older students, particularly the adolescents, believed there were worse places than New Directions, “The middle aged and adolescent kids do understand that there are worse places . . . [but] not the real little ones.”

Not only do some of the students believe they are being punished, others equate their participation in the program with “being crazy.” One therapist reported overhearing conversations similar to: “. . . ‘if you talk about [your] trauma, they [the staff] might think you are crazy, and they might keep you longer.’”

Concerning the group activities, the therapists expressed ambivalence regarding the play dough activity since the younger children (ages 5 through 7) did not understand the concept associated with the activity, and it became more of a game for some of the younger children. There was a consensus that the Safe Community project was overstimulating because it used too many toys and figurines; the children were more focused on the “toys” than on the goal of the activity. While the idea behind the project was appropriate, the therapists indicated that the method needed revision.

Another therapist shared that even the children said “not all of the activities work for everyone.” The therapist went to say that although the children were, for the most part, “open for any activity that was scheduled,” there are children who “choose not to engage or attempt to seek help.”
I asked if any of the therapists noticed any negative responses to the curriculum protocol from either themselves or the children. In response to the inquiry, the therapists expressed the consensus that the children “act out more during the day” and attributed this more to the children “remembering” [what happened to them and what they experienced], particularly when they were in the trauma group. The therapists recognized that the children had experienced a wide variety of traumas and had been grouped according to their levels of functioning—emotionally, socially, and educationally. The therapists described the levels of functioning as “very diverse,” making it difficult to address the needs of each child in the trauma group.

The therapists also noted that the children perceive participation in the trauma groups and also one-on-one therapy sessions as “none of [our] business.” The children viewed the activities and the questions raised as invasive. One therapist responded to the children in this way: “I cannot make them understand that ‘while you are here, you are my business . . . whether it happens at home . . . or here, it is my business’. They don’t understand why I am invading their privacy or why I want to know all this personal stuff about them. . . . That relationship is sometimes difficult for them to grasp. ‘I’m a therapist. I’m not your friend. I’m a therapist!’ They don’t get it.”

Another individual added another important concept: “It’s hard to explain things to them in an age appropriate way. I really struggle with that, not just in trauma but in other areas . . . even just getting them to understand what trauma means and what it is.” A third therapist agreed: “I don’t even think that they are aware of their trauma issues or what they have experienced as traumatic. They can’t understand why they’re in the
trauma group or understand why they are doing what they’re doing . . . that is especially true of how their experiences have impacted their lives.”

One description captured this notion: “My one client will spit out all this information with no show of affect change. She doesn’t even realize that what she is saying is totally shocking to some people. She blurts out ‘Well, this is what happened at my house’ and goes on with her day like no big deal. So, I think she is clueless that life for most people isn’t like that . . . like it is for her.” Another therapist added: “It amazes me how much you are able to get out of them without them truly understanding what it is they are saying.”

This led to me asking if anything could be incorporated into the groups to allow for better understanding of trauma by the children. Instead of answering the question, the therapists talked about “normal” behavior as it related to their clients. One therapist wanted her clients to “realize that they are not normal” and asked “how do you show that?” She went on: “If we could take each one of them home with us for a day and let them see how you are supposed to live . . .” Another quipped: “They might think we were the most abnormal people on the face of the earth.” The first therapist continued: “Right, so I don’t know necessarily how to explain trauma. I can’t explain normalcy to them. That’s where I’m hung up.”

I asked the therapists if their concept of trauma had changed due to their participation in the trauma groups with the children. Several of the therapists indicated that they originally associated trauma with rape or abuse but now realize that trauma is more than that. One therapist put it this way: “I see trauma as more broad than previously.
Events which I formerly did not see as ‘traumatic’ and now these things truly affect the children in traumatic ways.” Another therapist gave an example concerning one of her clients who had been in a serious automobile accident with their family. Everyone survived the accident with no serious injuries. However, the child was affected in several domains—prolonged sleep disturbance, anxiety attacks, fears, avoidance, unexplained crying, overreaction to other situations, and withdrawal from friends. “It opened my eyes to how many forms of trauma there are.”

Some of the therapists commented on their heightened awareness of the traumatic effects witnessing violence or adult substance abuse had on children. Several therapists said they remembered stories disclosed by their clients in which the children described traumatic events they had experienced. Although the children told of various experiences, they identified removal by CYS (Children and Youth Services) and the police as the “worst.” The children did not identify the action that precipitated the removal as terrible, rather, they identified the removal itself as traumatic.

In a related question, I asked: “What did you notice about your understanding of the effects of trauma on children?” Several clinicians stated they had gained an increased understanding of the connection between the children’s behavior and something that had previously occurred. Since beginning work at New Directions, one therapist not only participated in the children’s trauma groups, but she also attended a conference. As a result of her experiences, she reported being “more able to pick up on behavior or exploring more of what a child may say.” What she might have previously assumed was
just “defiant rotten behavior,” she now realized could be the aftermath of a traumatic event. “It’s just clearer for me,” she said. “I am more tolerant and more patient.”

Another therapist indicated that she had changed in her “understanding . . . why they react the way that they do, how they act the way they do, maybe how things affect them. Maybe it’s something that I do or something that I say [that] may affect them. Or something that a peer says or does. I am better able to . . . understand. And I am better for having shared the trauma group with them and hearing their stories, process[ing] with them, and it helps understanding behaviors. Like something I may have brushed off before, now I can see the connection of their behavior to . . . something [that] has previously happened. That helps me work with them in a more understanding way.” Yet another clinician presented “Initially when identifying children some behavior may have been minimized, if we had not incorporated the trauma groups behavior would not have calmed down or may have worsened.”

I asked the group if any of their course work or formal education focused on the effects of trauma. Almost everyone in the group reacted to this question: “We touched on it in a chapter,” said one therapist. Two others who had each taken a criminology course said they studied how someone’s trauma history can affect their life in crime. One of the therapists who had majored in Elementary Education reported having been instructed on how to notice if a child had been maltreated, but there had been no further discussion of what one should do. This last statement resulted in nods of agreement and statements of agreement from others in the focus group. Someone added: “We talked about what kind of developmental lag it can have, but that was it” and indicated that there was no further
processing concerning actions to be taken. Members of the group also indicated they had learned what to do from a legal standpoint (mandated reporting). Another therapist said he or she had an assessment class in which “there was some focus on trauma, however it was poorly taught.” The group concurred that they were never taught ways in which they could help a child feel safe or understand where their behavior had originated.

This led me to ask if she could do anything differently to help the clinicians grow in the area of trauma. One therapist offered, “Ideally, if we had you come in and teach us the whole curriculum.” Although acknowledging that was not a feasible request, she said that by participating in the trauma groups she had learned some things. Another suggestion was made regarding outside training: “There is nothing that can compare to that [outside training]... When you’re sitting in a training and having all of this generalized information and there is no face attached, you’re more open in that environment to sit and learn and take it all in.”

The therapist who had transferred to the children’s unit from the adolescents’ unit chimed in: “I’d like to observe one-on-one stuff. I think that would be helpful, to see you [referring to me] work with a kid individually... because, when they have the trauma group, they will have all this stuff inside, and I know when I did the adolescent group, when group is over, they will go to their therapist and unload. And if (a) their therapist wasn’t the one who was in the trauma group, or (b) they [the therapist] don’t have the background or they don’t have the experience, then you’re [the therapist] stuck in the place of ‘How can I do the best for this kid?’ Because I know, particularly with some of the girls I had in the adolescent group, when they went through the trauma group [they]
would be very quiet and would come to me afterwards and be like ‘blah!’ and unload on me and I would be like ‘dah.’” With her last comment, the speaker and others in the room laughed in understanding of the dilemma they all recognized.

Another therapist indicated some frustration in that she is a floater–a backup when other staff may be somewhere else, ill, or participating in training. While she attempted to know each child’s history or situation, she got stuck at times when a student discloses something that she cannot thoroughly process with them. “At times,” she said, “it works out.”

The feelings of the group were expressed by one therapist who stated: “You want to tell them ‘Everything will be OK!’ and that is the worst possible thing to tell them. But you are lost for words.” The group unanimously responded: “Right, right!”

I asked the therapists what they noticed about the group process. One therapist recalled thinking to herself during an individual session: “Why? Why are you telling me [this]? . . . Don’t disclose to me!” The group laughed in understanding. Then, the discussion continued as the therapists addressed the difficulty they had in listening to the “awful stories” and, at times, being uncertain as what to do next. “It feels like I’m not being very therapeutic and . . . helpful to that child. . . . I know consistency has to be there for these kids especially to trust and to process this stuff.” The therapists discussed another side to their work–believing “that the children can be manipulative.” This was evidenced when they compared notes and realized that the same children repeated their story to different therapists or groups within the program.
This group of therapists also expressed empathy for their clients when they [the children] had to continue their day following a disclosure “as if nothing had happened.” They compared it to the process the children may have experienced in managing the original trauma and acting as if it had not happened. One therapist put it this way: “I don’t know if I could do that as a normal, functioning adult.” A second therapist made a similar statement. One therapist commented that “you can tell more about what they [the children] are going through as they describe something that feels safe to them than describing the actual trauma.”

The therapists also reported that the children wanted to know about their personal lives; they reacted in different ways to the children’s probes. One individual shared her response to the children’s inquiries: “I’m a therapist. I’m not your friend. I’m a therapist. They don’t get it. I’m not going to tell them how my evening was. You don’t need to know if I have a boyfriend. You don’t need to know that stuff, that’s not really going to help you.” Another said that the children wanted to “divert” the conversation away from themselves. One therapist shared her response to a child’s question about her family. She indicated that her father lived “far away.” She then described the surprise expressed by her children because they “never thought of my having a father. They don’t see me as a human being. They see me as a [super] human and . . . I can do no wrong.” While there was further discussion concerning sharing personal information with the children, it was generally agreed that the information should be “limited” and “controlled.”

Several other notions were shared by the therapists. They identified the verbal and physical aggression that occurred on a daily basis in the program and reported that some
children are so out of control that they could not function in the trauma groups. They also indicated that the children did not “necessarily care what others are saying.” “They are selfish. Their world is all about them.” Another therapist said that developmentally, the children are still in what is called the “parallel play” rather than interactive mode.

When asked if they believed that the trauma group is appropriate at New Directions, the therapists responded in the positive. “It is necessary, I would say 90% of our kids have some kind of trauma history. . . . I don’t see how we can get around without having it here.” Several therapists said the trauma groups were introduced into the program because they were needed, so that the children could get help. They said they believed the trauma groups help the children: “Something happens, something shifts.” The focus group members agreed that, in general, the trauma group was the “most intense” group the children attend. They also agreed that, for the most part, it works.

I asked the group if they thought the trauma curriculum had affected the program at New Directions. One individual said: “I’ve had daily review [group] and they have all opened up and disclosed trauma and it was like WOW! They really got it they understood it! They’re really proud of themselves for doing it. And, then there are other days when they I just . . .” don’t have much to share.

In general, the group was in agreement that the trauma groups educate the children “to realize that there is a different way to be.” They begin to realize that “it [traumatic events] has happened to other people and . . . they are not alone and . . . whatever they feel, they’re not wrong for feeling that way.” One therapist reported that the children who were in the trauma group “connected” with each other and may not have done so without
the intervention of the group. She reported that the children came to realize they were
“vastly different from one another” other than that “one huge event” [the traumatic event]
in their lives. Through the group process, the children were able to identify what had
happened to them in an appropriate fashion. However, she said the children were unable
to “manage the inside stuff” which contributed to the “problem behavior.” Speaking of
the various groups in which the children participate, two therapists agreed that the trauma
group is “the most intense group” they attend. Another said that the group “shows them”
how to manage their feelings and “really helps them.”

When asked what they had noticed about themselves, similar responses were
heard: “People say you have to learn to leave it at work. That is not always so easy.”
“When someone has been verbally assaulting you all day” or you go home with “bruises”
or “you have to get checked medically because someone spit in your face or bit you,” you
realize that as a group, they have “learned to support each other” by listening and by
occasionally doing things together. Some reported that their significant others or family
members did not understand. Speaking of the effects of working in the program, one
therapist said “we take it [the effects of the job] wherever we go.” They related that it
means a lot to them when others acknowledge their help during the day or when someone
asks how they are doing after an incident. “It really helps. Some days are difficult.” They
felt they were doing better as a team by supporting one another. It gave them the impetus
to return to the facility day after day.
Emerging Themes

Twenty-one themes emerged from the focus group held with the children’s therapists. Those themes included application of interventions, behavior problems, boundaries, client growth, clinical growth, cohesion, counter-transference, culture, development, diagnosis/symptoms, disclosure, empathy, environment/structure, family systems, lack of training, organization/structure, process, sensory, support for trauma groups, theoretical orientation, and vicarious trauma. They are discussed following Table 4, which contains a list of these themes.

Table 4

Emerging Themes from Focus Group with Children’s Therapists

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Application of interventions. The therapists reported seeing the children perform the opening trauma group exercises in their academic classes. They also reported seeing the exercises performed in other areas of the program.
Behavior problems. The therapists discussed both physical and verbal aggression on the part of the children. They also said that older children became irritated with the younger ones.

Boundaries. The therapists said that they did not disclose personal information to their clients. They defined their roles as “therapists” to the children.

Client growth. Through the group process, the children were able to identify what had happened to them using appropriate language. The children learned how to respect each other and work with each other.

Clinical growth. The therapists reported an increased understanding of why the children react and act the way they do. They stated that things were clearer from “hearing their stories and having shared their stories” and indicated they were “better able to understand.” One therapist said: “It opened my eyes to how many forms of trauma there are.” The therapists also discussed having an increase in their tolerance toward and patience with the children.

Cohesion. The therapists reported getting a sense of cohesion from several of the activities and “learning to do the exercises together.” They said that the exercises were a “constant.” Regarding Moonball and the drawing interventions, they commented that “allowing them to form some kind of team with cohesion is important.”

Counter-transference. A therapist, commenting on one of the children, said: “I think she drew a picture and couldn’t connect it to anything, which is why she didn’t share.” Another stated, in response to the horrible stories the children shared: “Why?
Why are you telling me this?” Yet another therapist indicated: “My head spins because of the stories they [the children] tell.”

_Culture_. In the focus group, the therapists discussed the “chaos” in the lives of their clients. They described it as a “long progression from their grandparents to their parents . . . ” and said that no members of the families understood normalcy.

_Development_. The one therapist who had facilitated both the adolescents’ and children’s groups noted “what the children grab onto is different compared to the adolescents.” The therapists presented that the children were not aware that their experiences had been traumatic. One therapist shared: “One client spits out all of this information . . . no change of affect . . . clueless that life for most people isn’t like that.” Another said: “. . . nothing in their lives is a typical kid’s atmosphere.” In general, they agreed that the children in the groups were not interactive and referred to the children’s actions as “parallel play.”

_Diagnosis/symptoms_. This theme was exemplified by several statements: A “client spills out information that would shock most people with no show of affect change.” “There are those children who cannot function.” “. . . 90% of our kids have a trauma history.”

_Disclosure_. The therapists discussed situations in which their clients had made disclosures, particularly when others in the group indicated they had similar experiences. They said the children “disclosed trauma and were proud of themselves” for having done so.
Empathy. When the therapists discussed the children speaking about their traumas, they did so with empathy: “I don’t think I could tell someone the most horrible thing that ever happened and then go to class and follow directions and act as if nothing had happened.” “You don’t say this, but you want to tell the kids, ‘Everything will be OK.’”

Environment/structure. Several therapists expressed a desire to hold the trauma groups in a different location, one which was calmer and quieter in which “you cannot hear kids yelling and screaming in the hall.” They said that the trauma group “is the most intense group” they had, but it was “thrown in the middle of the day.”

Family systems. In discussing family systems, the therapists spoke of problems being seen “generation to generation.” They used the term “chaos” in reference to the children’s families and said that “normalcy” was not understood in the families. One therapist said: “If we could take each one of them home with us for a day and let them see how you are supposed to live . . . .” Another quipped: “They [the children] might think we are the most abnormal people on the face of the earth.”

Lack of training. In discussing where they had learned about trauma, some of the therapists reported learning about it in unusual settings, including a criminology class. Others said they learned how to assess for maltreatment but not what to do after that. One therapist said she learned that trauma can contribute to developmental lags, but she did not know what to do about that. In general, they said that knowing where the behavior comes from and how to help a child feel safe was not something they had studied.
**Organization/structure.** The therapists reported that the trauma groups were introduced into the program, because they were needed by the children. They said that the trauma groups helped the children.

**Process.** In discussing the process, the therapists agreed that “it’s a short period of time to present something and ask them [the clients] to process it.” They stated a desire to want to help the children talk about situations, process what they discussed, and “be OK.” They also cited a need for consistency.

**Sensory.** Due to the movement and physical activity involved in throwing the ball and being allowed to “yell out,” the Target Practice exercise was discussed by the therapists as a safe way for the children to express their emotions. The therapists said it was “OK” for the children to be angry.

**Support for trauma groups.** In citing support for the trauma groups, the therapists agreed that the experience taught the children “there is another way to be.” One therapist stated, “If we had not incorporated the trauma groups, behavior would not have calmed down or may have worsened.” Several therapists concurred. One said, “I don’t see how we can get around without having it here.”

**Theoretical orientation.** Several therapists reported seeing a connection between a child’s behavior and something that happened to the child previously. They reported that the children’s previous experiences had affected the children’s lives.

**Vicarious trauma.** The therapists reported harm to themselves: “. . . sometimes bruises, assaults, having someone spit at you or bite you.” They said some of the
information was “hard to leave behind.” They also reported that support from others and the ability to process helped them.

First Focus Group with Parents and Caregivers

The setting. The first of two focus groups held with the parents and caregivers of the children and adolescents who had participated in the trauma groups was held on May 7, 2003. Seven individuals met with me in a classroom at New Directions. Immediately preceding the focus group, I met with the parents and caregivers in attendance at a regularly scheduled meeting at New Directions. At that time, I made a presentation on the effects of trauma on children. Please note that a reference to “parents” in the succeeding discourse pertains to both parents and caregivers.

Because transportation is a challenge with the families of the children at New Directions, it was decided to combine a presentation on the effects of trauma on children with the focus group. A flyer giving the specifics of the meeting was sent home with the children and adolescents.

The session. The parents were attentive during the first part of the program. As the discussion began, one woman quickly spoke up, wanting to share a story involving the purchase of new bunk beds. She said she knew something was wrong because her foster son had begun to have sleep problems and nightmares soon after the purchase. Although she knew he had a trauma history, she was not aware of the specifics. However, she knew her foster child was terrified of bugs and things related to bugs. Still, she did not “connect” his trauma history with the new beds. Then, one day, she crawled into the lower bunk and looked up, amazed to find that the upper bunk mattress was covered in
fabric that resembled a spider web. She took her son to a fabric store and had him select material that he liked, a dog print. She placed the fabric under the mattress of the upper bunk so that her son could see the dog print when he looked up. The sleep disturbance stopped and nightmares were reduced to occasional occurrences.

In order to engage other parents in the focus group, I asked the participants to share their thoughts and opinions regarding the inclusion of the trauma groups at New Directions. After what seemed like hours, a parent responded: “Whether our children are going through this or not, if they come home and we, as parents, don’t know they are going through this group . . . if we understand better what they are going through, it would help them.” I asked “Do you mean support them?” in order to clarify what the parent had stated. Another parent responded: “Exactly.”

I explained to the parents that one objective of the trauma groups was to find creative ways in which the children could control themselves and avoid emotional outbursts. She went on to discuss several of the exercises the children could use in their classes, on the bus, or at home. The Pretzel was one of the exercises described to the parents. The parents laughed at the description and one parent said: “At another meeting here . . . someone had mentioned that and I never fully understood what it meant.” She added: “Anything that will help him come out of this.”

I asked how many of the parents had someone who had gone through a trauma. All seven of the parents nodded “yes.” One of the parents asked if “the children or teenagers ask to go [to] the groups.” I explained that most often they are assigned by the

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3 A description of this exercise can be found in Chapter III.
therapists but that several adolescents had attended twice at their own request. She explained that the reaction of the two adolescents was different from the reactions the previous year in which the response to being assigned to the trauma groups was “No! Not me.” The parents laughed in understanding.

One parent commented: “My son’s ex-girlfriend left [her son] at our house, and he has been with us ever since, several years now. He, for sure, went through some things we do not know about. I would like more resources to understand what happens to kids after the trauma.” I informed the group of a website and provided some background on the site.

This led me to ask if any of their children had talked about the war [in Iraq]. The parents immediately responded. One parent reported that several adults were discussing the war. Their son spoke up and said “I live in this world too. I want to know what is going on.’ It blew me away ’cause I didn’t think he would be interested in it.” Another member related that their son is into the war and asks them if they pay attention to what is going on. “He gets very paranoid and stuff like that.” When asked if he expressed fear for his family, the parent responded in the affirmative.

One parent began a discussion of an event reported on CNN [Cable Network News]. “There was a school shooting in eastern Pennsylvania. They showed them dismissing the kids. . . . He [the perpetrator] took a couple of guns to school, went and shot the principal and then went and killed hisself. He was in 8th grade, 14 years old. It was on the news.” According to the news report, the student “told a couple of the friends they interviewed. They said that he told them that he was going to bring guns to school,
but that they didn’t believe him.” This parent was obviously affected by the story of the 14-year-old because she continued with the discussion on CNN.

The same parent continued by discussing other tragic events reported on CNN including “a tornado hitting down in Texas someplace, and it showed a mobile home.” She then said she did not want her granddaughter to see the news report “’cause we live in a mobile home and . . . it will get on her mind.” She added that they were on their way “someplace and we come home and saw this mobile home was on fire and she [the granddaughter] said ‘Oh. Let’s stop.’” She reported that the granddaughter had added: “‘I wonder if anybody is in that mobile home?’” She continued: “Thank God there wasn’t. The people wasn’t home at the time. . . . and she [the granddaughter] has one of these porcelain dolls and Barbie dolls and she worries about our place being on fire.”

Another individual chimed in: “We was in a fire. Our place caught on fire. He [her grandson] was upstairs; I was downstairs and I woke up and smoke was all through and flames was flyin’ upstairs and it was a lot of trauma and everything.” When asked if he ever talked about the incident or reacted to things such as a fire truck, she said: “He doesn’t react, but he talks about it.” I provided some information on how to handle children when events such as the fire occur. She emphasized the importance of discussing such matters with children to prevent them from keeping things bottled up inside them. One parent concurred: “They are socking these things away.”

One parent asked if there were “physical ways that you can tell that this is a repressed thing within this child?” I explained that indicators could range from nothing to 100% and indicated some of the signs. One parent made an astute comment: “It’s so hard
to tell with that though. Because, if you have a kid with ADHD and all these things [are] going on all at one time, . . . sometimes I think it’s the trauma and other times it’s the ADHD. . . . I have a real hard [time] to tell what it is.” I confirmed that some aftereffects of trauma parallel ADHD symptoms.

One of the quieter parents spoke up: “So, it’s really great that this is going on simultaneously in this program because, otherwise, it would just be passed off as ‘Oh. It’s ADHD!’ . . . and you would never get to the root problem which may be something traumatic.” She continued: “. . . as a child, I was grown up and raised around an alcoholic father . . . he’d come in and disrupt everything. I did not realize how much it bothered me until . . . these last couple of years when I started dealing with my past. Like, I didn’t want to be around anyone who drank. I didn’t want any of that around me. I just put myself in a plastic bubble and, when anything come near me, I, I couldn’t handle it. So, I started. I try to work on myself because if you don’t work on yourself and you don’t want help, then all the help in the work, you might as well forget it. It starts with you.” She commented on addressing issues in her past: “. . . not thinking about . . . things as a child were affecting me as an adult so I started unloading those” things and putting them behind her. “. . . like I had to go over each individual thing and I had to throw them out of my cart, get rid of it. Don’t think that just because you had a childhood and you’re an adult now that everything is OK because, if you’re having problems, believe me nine times out of 10, they’re coming from something way back there. Go back and deal with it.”
Second Focus Group with Parents and Caregivers

The setting. The second parent group was held at New Directions on Family Fun Day, June 3, 2003. Eight parents participated. I was concerned that the parents would not respond because this was a family day, and the meeting was held during free time in the same room as other activities had been held. There was a great deal of background noise. I was in the middle of the introduction when a parent blurted out: “It’s a good thing to check in with us parents and maybe somebody outside of here will pay attention to what these kids are goin’ through.” Another remarked: “That is so true. Few people understand what happens to kids who have problems.”

The session. After completing the requisite forms, I asked the parents what they thought about trauma and what they considered a traumatic situation. The parents responded immediately: “Trauma is something that really scares you or really upsets you.” Another responded: “. . . the very worst trauma is separatin’ those kids from their parents, that hurts ‘em real bad, and they don’t always understand.” And another gave a specific instance of trauma: “he was stayin’ with his mother, came to visit us, and she called and said he was too much and didn’t want him.” She went on: “I wasn’t his mother, but he would, and still does, talk to me. He’s been abused. Just started talking about it.” The child’s biological father added: “Somebody beat him. Don’t know who.”

Another parent contributed a similar situation: “Sometimes you don’t know what all happened. I have my daughter’s sons, as she is seriously ill and cannot care for her children. [One of them] is six, and he saw medical personnel place a shunt in her arm in the ER. Shortly after he came to live with me, he needed lab work done at the hospital.
When the staff went to take blood from his arm, he absolutely flipped out and believed he was getting a shunt. There is no way I [could have known] that would upset him and turn into another traumatic situation for him.” She added that the other traumatic issues in his life were “being fearful of a new environment and also being separated from his mother.”

More stories followed: “My granddaughter is so afraid she’ll be taken from me. . . . Her mother just didn’t bother with her. She needs constant reassurance that this is her home, and, if we argue, she almost panics that I won’t keep her. Never have I mentioned that she would not remain, not even as [a] threat when she is not listening or pleading relentlessly for something. That fear is always with her.”

Another individual shared: “I have three nephews staying with me; two of them have attended here. Even though they have witnessed violence and have been physically abused, the worst thing for them, as bad as it was, was the removal from their home by CYS and police. They were sleeping on mattresses without sheets, and there was little food. They saw adults using drugs and violence, but the removal is what they talk about. It is only recently [that they] have been able to say that they do not want to go back to the way things were.”

I asked the adults if they were aware that their children were participating in the trauma groups. Several responses followed: “Our son told us after he had been in the group awhile.” “I think his counselor told us he was going to be in it.” “She [the counselor] told me about it and said she [the child] was starting to talk more.” “I did not know he went to them groups but I kinda remember getting information about some new group.” “I was quite aware he was in the trauma group and I think that was good for
him.” Another parent said to the group: “My son went through a fire, and the babies [his siblings] died. The [trauma] group and this lady [referring to me] helped my son talk more. He is doin’ better.”

A late arriver laughed as she sat down in “Pretzel” form. The other parents joined in the laughter. Her demonstration led, without direction from me, into a discussion of the Pretzel.

One parent remarked that she had two children in the trauma groups during the previous year. One of the children “never talked about it,” while the other “mentioned it.” However, she said that had changed during the current school year: “But this year, when he started having problems, it was only after he started talking to you [referred to me], did I notice him doing the exercises which has helped him manage much better. I saw him use the Pretzel when he was mad at his older brother. He walked into the living room and sat down to do it, and he avoided a nasty fight, which normally happens. It is nice to see.”

Another parent joined the group late. Several of the parents had been involved with Family Day activities and two of them had arrived late to the focus group. I indicated that the group was discussing whether or not the parents were aware that their children were involved in the trauma groups. Chuckling, she immediately began to demonstrate the Pretzel and tapping.4 When one parent said, “I saw him doing that thing he called the Pretzel; he told me it calmed him better,” another added: “Is that what that is? We were in church and I looked over and my grandson was doing those tap things and I said to him

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4 Refer to Chapter III for a discussion of these techniques.
‘What in the world are you doing in church?’ and made him stop. I didn’t know what that was.”

When asked if they had any suggestions concerning the trauma groups, one parent said that she would “like to read some information . . . about the effects of trauma on children,” saying that it could be helpful for parents. Another parent indicated that, as “fill-in” parents they “don’t always get it [understand]. Some information would be helpful, at least for me.” Another commented: “I think a meeting with the parents before the group starts would be good, and you could tell us what’s gonna’ happen and help us help our kids more.” Others voiced agreement to these proposals.

I asked if New Directions was an appropriate setting for the trauma groups. A grandparent opened up immediately: “I’ve gone back to school, at Penn State, and I think that someone needs to be getting these kids to talk about what they lived through, and [they should be] given some tools to help with those big feelings that go haywire. Too many times, counselors try to do charts and stickers and don’t pay any attention to what is going on behind the behavior. I’m tired of the stickers and charts. Start talking to these kids so they can start to open up. I can’t think of a better place for these groups.” She got support from another parent: “Ditto on the charts and stickers. The kids have to get that stuff inside out and need to know it is OK to talk about it and be safe at the same time.”

Other parents voiced their support of the inclusion of the trauma groups: “I think it needs to be here,” said one parent. Another said: “they helped my son start to talk to us. I think New Directions has done a good job with our son. He couldn’t succeed at regular school. He needed help.” Another said: “It has helped my granddaughter hear other kids
talk about their problems. The groups belong here.” This portion of the discussion ended with the following comments: “Ain’t no one gonna’ learn if they’re upset by what has happened to ‘em. Head don’t work that way. They gotta talk somewhere where people like the counselors here understand. Them kids know who gets it and who don’t. We’ve talked to some dumb people [therapists] who don’t get it.”

I asked the group what they would like to see happen at New Directions. One parent spoke up with: “I’d like to watch one of these groups. In a circle with the children, with the counselors, and tell them how we feel.” The responses to this suggestion tumbled out: “They [the children] wouldn’t talk.” “They [the children] need to know. They need to know it’s hard.” “That would be a hard group.” “We may not [want] to be together ‘cause children will say things that will hurt a parent’s heart so bad.” “Now, how can you leave that stuff on the table and go on back home?” “Maybe we can listen in, like when they are havin’ a conversation in a meetin’ . . . without them seein’ us.” “The thing is, with the parent sittin’ there, the child isn’t goin’ to want to say what they really feel.” “We got feelin’s too, just like the kids do.” “I find myself, honest to goodness sometimes, and they don’t know that I do it. I go downstairs and punch a punching bag and get my frustrations out, and it calms me down.”

At this point in the conversation, the Family Day activities were peaking, and I asked the parents if they wanted to join their children. Some of the parents left the group in order to engage with their children. A few parents had more to say: “My son has come a long [he emphasized the word “long”] way.” Another said: “I still have problems at home. He’s doing good in school, and I think I know why.”
Another parent wanted to share her story. It is included at this point as representative of the living conditions which these parents and the children endure. I overheard a parent make a comment about water and asked for an elaboration. The parent explained: “We have to carry water in this trailer, and we have no commode now because the township said you have to have a tank inside the ground, and, if that tank remains there, it’s a $500 a day fine, and we have to move, and that’s what we’re doing. And, Welfare and Community Action said they would try to help us. More than likely, I’m homeless right now. I still live in the trailer.”

I asked the parent: “How do you think that affects the boys?” “It affects them real bad, but they still want to stay, because they still have animals, and I don’t like it. I don’t like it. I’d rather have a commode and water. I’m tired of carryin’ water in, especially when I got other things to do. I got to clean house, take care of responsibilities, and that puts a lot of pressure on them, too. And, now I have to move because I’m with somebody who’s goin’ back to his wife, and he’s more like a kid. He has an adult’s body but a mind like a kid. Too many bosses. I want to be the parent. Let me be the parent. And, they said they was goin’ to get adopted, and I know that they heard it from somebody’s mouth. My kids are not gettin’ taken away from me. I’ve not been bad to ‘em.”

When asked by another parent why the children would be “taken away,” the mother responded: “Because when they run away, well, people said they was taken off me. . . . Where would they hear adoption at? They went up to the guy who I just broke up with, his wife’s house, she’s more of a mom than me. I don’t know what it is, but they’re angry. That’s why. The one guy I see got very upset with me ‘cause I told him he had to
clean up his mess ‘cause I just had cleaned it. He says, ‘I’m tryin’ to watch the movie so shut up. I’ll clean up the mess later.’ He got up off the couch. I pointed my finger. He got very mad. I just pointed my finger. I did not touch him. He pushed me and shoved me. My cousin, I have to go and see a therapist at Chestnut Ridge. She said that’s why I have to go right now, see a therapist. I don’t like that. I should not have to see a therapist.”

And, with this, the conversation ended.

Emerging Themes

Although there were two parent focus groups in which different parents participated, collectively, the themes that emerged from both groups are representative of the parents as a whole. Twenty-one themes emerged from the two parent focus groups. These themes included additional interventions, application of interventions, behavior problems, client growth, communication, counter-transference, culture, development, diagnosis/symptoms, disclosure, empathy, environment/structure, family systems, lack of training, organization, parental involvement, poverty, process, safety, support for trauma groups, and theoretical orientation. Table 5 contains a list of these themes. A discussion of them follows.

Additional interventions. Suggestions were made concerning parental involvement in the trauma groups. One parent in the second group said “I’d like to watch one of these groups. In a circle with the children, with the counselors, and tell them how we feel.”

Application of interventions. Several statements made by the parents in the second focus group contributed to this theme. For example, “But this year, when he started having problems, it was only after he started talking to you [referring to me], did I notice
him doing the exercises which has helped him manage much better. I saw him use the Pretzel when he was mad at his older brother. He walked into the living room and sat down to do it, and he avoided a nasty fight, which normally happens. It is nice to see.” A second parent said: “I saw him doing that thing he called the Pretzel; he told me it calmed him better.” Another added: “We were in church and I looked over and my grandson was doing those tap things and I said to him, ‘What in the world are you doing in church?’ and made him stop. I didn’t know what that was.”

Table 5

*Emerging Themes from Focus Groups with Parents*

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<tr>
<th>Additional Interventions</th>
<th>Development</th>
<th>Organization</th>
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<tr>
<td>Application of Interventions</td>
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<td>Behavior Problems</td>
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<td>Client Growth</td>
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<td>Counter-transference</td>
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<td>Support for Trauma Groups</td>
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<td>Culture</td>
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<td>Theoretical Orientation</td>
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*Behavior problems.* In the first parent group, one parent said that her child, as well as other children, was internalizing emotions. She referred to it as “socking these things away.” This theme was also addressed by a parent in the second parent focus group who said, in acknowledgment of the child’s problem, that her grandson “absolutely flipped out.”
Client growth. One parent in the second group remarked that his son had “come a long way” since being involved in the trauma groups at New Directions. He observed the child doing the Pretzel because “it calmed him better.” Another caregiver in that group was responsible for three of nephews. They discussed the removal from their mother as the “worst thing” that had happened to them. Over a year later, they said they did not want to go back to the way things were.

Communication. One parent in the first group mentioned attending another meeting at New Directions in which the Pretzel was mentioned. She said that she “never fully understood what it meant.” Another parent said that knowing what occurred in the trauma groups would assist the parents in helping their children. In the second parent focus group, several parents indicated they had communicated with the counselors about the trauma groups and about their children. One parent said: “It’s a good thing to check in with us parents, and, maybe, somebody outside of here will pay attention to what these kids are goin’ through.”

Counter-transference. The researcher had commented that several children had repeated the trauma groups. A parent in the first group said that the adolescents wanted to go through the groups again, because so “[felt] good.” In the second focus group, one parent suggested parental involvement in the trauma groups. Another parent responded to the comment and said that children “will say things that will hurt a parent’s heart so bad.”

Culture. The culture of one of the families was captured in a statement made by one of the participants. “… we was in a fire, our place caught on fire, he was upstairs, I
was downstairs, and I woke up and smoke was all through, and flames was flyin’ upstairs, and it was a lot of trauma and everything . . . .”

*Development.* One parent in the first group shared, in explaining how her son was growing up, that several adults were discussing the war. Her son spoke up and said, “I live in this world, too. I want to know what is going on.” She went on to say, “It blew me away ‘cause I didn’t think he would be interested in it.” In the second group, there were at least three instances in which a parent or caregiver comment on not knowing the history of the child in their care. This impinges on developmental issues. One child’s biological father commented that someone had beaten his son; however, he did not know who. Another parent contributed a similar situation: “Sometimes you don’t know what all happened. I have my daughter’s sons, as she is seriously ill and cannot care for her children.”

*Diagnosis/symptoms.* In the first group, one parent said it this way: “It’s so hard to tell . . . because, if you have a kid with ADHD, and all these things [are] going on all at one time, . . . sometimes I think it’s the trauma, and other times it’s the ADHD. . . . I have a real hard [time] to tell what it is.” In another incident, a second parent described their son as “paranoid.” In the second parent focus group, a grandmother commented that her grandson had “traumatic issues in his life.” She said he was “fearful” of new environments and that being separated from his mother was traumatic for him.

*Disclosure.* In the second parent focus group, one foster aunt spoke of her nephews. She indicated that, after a year with her, the boys had finally admitted they did not want to return to their previous environment.
Empathy. One grandmother from the first parent group expressed concern for her granddaughter when they were watching a CNN report of a mobile home on fire. She indicated she did not want her granddaughter to view the new report because it would upset the child. In the second parent group, the participants empathized with the problems the children at New Directions had. One father commented on the type of information the children disclose: “Now, how can you leave that stuff on the table and go on back home?”

Environment/structure. One foster grandparent in the first focus group asked for additional resources in order to better “understand” what happens to their children after the trauma. She had requested this information from New Directions.

Family systems. One parent from the first focus group disclosed, “as a child, I was grown up and raised around an alcoholic father . . . he’d come in and disrupt everything. I did not realize how much it bothered me until . . . these last couple of years when I started dealing with my past.” Family systems for many of the children and their parents are chaotic; this was evident from discussions in the second parent focus group. The children may be living with one parent or the other. Sometimes they live with another relative. Sometimes, children are not “wanted” by a parent: “He was stayin’ with his mother, came to visit us, and she called and said he was too much and didn’t want him.” Discussions of traumatic events often take some time: “I wasn’t his mother, but he would, and still does, talk to me. He’s been abused. Just started talking about it.” Often, one or both parents know little about the things that happened to their child: “Somebody beat him. Don’t know who.”
Lack of training. In speaking of therapists their children have experienced, one parent in the second focus group said “We’ve talked to some dumb people [therapists] who don’t get it.” They also referred to “charts and stickers” the counselors have used in discussing their children. The parents commented that the counselors “don’t pay any attention to what is going on behind the behavior.”

Organization. This theme emerged in the second parent focus group. In referring to the New Directions organization, one parent said “I think New Directions has done a good job with our son. He couldn’t succeed at regular school. He needed help.” Another parent said that children “gotta’ talk somewhere” and suggested that the counselors at New Directions understood how to do that and also understood the children.

Parental involvement. One parent from the first focus group indicated a need to know more about the trauma groups so that parents could be more supportive of their children. He said: “Whether our children are going through this or not, if they come home and we, as parents, don’t know they are going through this group . . . if we understand better what they are going through, it would help them.” Describing themselves as “fill-in” parents, one individual in the second parent group said they don’t always understand everything that happened with their charges and indicated that additional information would be helpful to them. Another commented: “I think a meeting with the parents before the group starts would be good, and you could tell us what’s gonna’ happen and help us help our kids more.” Others voiced agreement to these proposals.

Poverty. The poverty in which some of the families lived was characterized by one parent in the second group who explained that they must “carry water” to their trailer.
She said they had “no commode” because they needed a “tank inside the ground” in order to use the commode. She went on about the inconveniences the lack of water caused.

**Process.** Several parents in the first group inquired about the process undertaken in the group. They also inquired if the children and adolescents requested to participate in the trauma groups. In another example, a set of parents related how their son managed the aftermath of being in a house fire: “He doesn’t react, but he talks about it.” and “A little bit, he talks about it and stuff.” In the second focus group, the parents discussed how they deal with their frustrations. One parent commented: “I find myself, honest to goodness sometimes, and they don’t know that I do it. I go downstairs and punch a punching bag and get my frustrations out, and it calms me down.” Another parent remarked that her two children, both in the program, processed things differently—one of the children “never talked about it,” while the other “mentioned it.” In another example of process, a parent arrived late to the focus group and sat down in “Pretzel” form. The group laughed. Her demonstration led, without direction from me, into a discussion of the Pretzel.

**Safety.** A set of parents in the first focus group related that the family had experienced a house fire. They reported that the fire changed the family’s sense of safety. In the second parent focus group, a parent brought up the issue of safety. She said: “The kids have to get that stuff inside out and need to know it is OK to talk about it and be safe at the same time.”

**Support for trauma groups.** One parent from the first group provided a positive comment about the continuation of the trauma groups. She said, “it’s really great that this is going on simultaneously in this program.” In commenting about the involvement of the
children in the trauma groups, one parent from the second focus group said: “It has helped my granddaughter hear other kids talk about their problems. The groups belong here.” Another parent commented: “I can’t think of a better place for these groups.”

Theoretical orientation. In reference to the “charts and stickers” used by some counselors, two parents in the second focus group expressed their frustration with their use and suggested the counselors should begin talking to “these kids so they can start to open up.” Another parent commented that no one will learn if they are upset. He continued: “Head don’t work that way.”

Focus Group with Pittsburgh Professional Society for the Study of Trauma and Dissociation (PPSSTD)

The setting. As I entered the familiar library at the Religious Society of Friends (Quakers) house, I wondered what their reactions would be to the curriculum I had asked them to review. No matter what, I knew they would be objective. After reviewing all the forms and obtaining the needed signatures, I began to audio-record the session. The members present were given 15 minutes to review the curriculum before the formal discussion began. I noted group members nodding their heads as they read through the curriculum. Then, the discussion began in earnest.

The session. Initially, they inquired about the diagnoses of the children at New Directions. They were particularly interested about trauma diagnoses, PTSD, Dissociative Disorders, or Reactive Attachment Disorder. I explained that even though about 80% of the children had a trauma history, the primary diagnosis was ADHD. This led to a spirited
discussion about the need for separate diagnostic criteria for PTSD and Dissociative Disorders in children. Research in this field has reached the same conclusion.

They suggested expanding the description of attachment disorders in the curriculum itself: “You’ll expect, in the groups that you have run, to see avoidant children. . . . You will see the different forms of attachment, I’m sure. If you are seeing that, it would be good to have a little section [in the curriculum] as children are notoriously avoidant, clingy, or disorganized.” Another member added “Just by observation, one could notice attachment styles among the participants.”

After reading the descriptions in the curriculum, several of the members tried to perform the Brain Gym® exercises. Several individuals asked for a demonstration and one therapist remarked, “You really described the exercises so that I could visualize them, and I was trying to do a couple of them.” They inquired as to how the activities were received by the children, what worked, and what did not work.

In response to the question “What does it mean that the therapists assign points at the end of the session?” I provided an overview of the New Directions program and described the token economy used at the facility. The children may earn “dollars,” or points, that are assigned by the therapists based on each individual’s behavior within an activity or class period. After each trauma group, the therapists would rate each child’s behavior and provide play money to the children who would carry it in a pencil bag. The adolescents are assigned points and the therapists wrote the number of points assigned on the adolescent’s point card. It was suggested that a more extensive description of the point system be included in the curriculum.
Further questions arose regarding the involvement of the New Directions staff in the trauma groups. I explained that there were always two child therapists in the children’s group in addition to me, due to the number of children in the groups as well as to help with behavior problems that could arise. One therapist was assigned to attend to any child in the group who was having difficulty and needed individual attention. In the adolescent group, one therapist was always in attendance. The assigned therapists remained consistent throughout the six or eight-week course; however, each section allowed for different therapists to be involved and learn the curriculum.

They also inquired about the schedule. I indicated that the time allotted for a trauma group was equal to a class period and fit the program at the partial. I suggested the trauma groups meet on Monday, Wednesday, and Friday; this suggestion was accepted at the partial.

One person asked: “You indicated several children went through the curriculum more than once. Was that beneficial to them?” I explained that three children and three adolescents went through the groups more than once; all chose to do so. The staff and I agreed with the requests and it seemed that the adolescents had more of a benefit than the children. Several members of the focus group who worked with children and adolescents at a rape crisis center supported my statement and offered: “We have been doing a 12-week trauma group for this population. We noticed a difference when they ran it a second time, and many were repeating the group. It was only after the second trial [that] the children told the therapists that they believed them and were trusting them.”
Another member who worked at the rape crisis center commented: “We were trying to find some consistent exercises that can be done at the beginning and the end” of each group session because their clients are 13 and 14 years of age. She said that things got “a little bit chaotic.” They offered that descriptions of the interventions and exercises were clear as they were able to demonstrate the brain gym exercises by following the written words. Several others wanted to implement some of the interventions with the children and adolescents see professionally. Some of the individuals saw the interventions and exercises in the curriculum as having potential with adult Dissociative clients, and members from the rape crisis center in requested a copy of the curriculum.

The group questioned me as to the decision to use the Brain Gym® exercises and how my clinical experience was used in the creation of the curriculum. They also asked if my intuitiveness affected the creation of the curriculum, particularly regarding the selection of interventions. I indicated that the exercises selected resulted from a professional training I attended at PAAR (Pittsburgh Action Against Rape). The individual who ran that session was a trainer of Thought Field Therapy. I had implemented the exercises on the inpatient unit where I had previously worked. The exercises were effective for relaxation and calming. One of the exercises, the Gentle Crossover, was an exercise used in the Brain Gym® program but was called Hook Ups. The same exercise was referred to as the Pretzel by the children at New Directions.

The consensus of the focus group was that there was an abundance of various kinds of movement in the curriculum. Considering the “energetic activities” in which the children and adolescents engaged, the group asked if the children were able to settle
down. I responded that, from her observation, the children were able to transition from an activity to processing and onto something else without much difficulty.

An observation raised by this group included the concept that “the curriculum helps the children and adolescents identify their feelings . . . which comes from the era of affective education and values clarification in the schools.” A therapist commented: “Back then, with affective education and values clarification, schools were saying that all kids needed to do what you’re describing here. There’s a lack of kids . . . able to express themselves, and they’ve different feelings and need acknowledgment for these different feelings and need help to transform it [their feelings].” Several of the therapists recalled that the Magic Circle was from the 1970s, and that it was considered “controversial” when implemented in the schools because the children were divulging “family secrets.”

Questions were raised concerning the Safe Place intervention. Safety is basic to trauma therapy and the Safe Place intervention is used in many environments. The focus group members said that it was typical in their clinical practices to have clients say: “There is no safe place.”

The focus group also offered suggestions for future research including a quantitative study that would utilize a control group for children who were not traumatized. They acknowledged a strong educational component in the curriculum. It was their thinking that many children could benefit from participating in the curriculum. Several individuals stated that “a study of traumatized versus non-traumatized adolescents” was indicated. It was suggested that trauma groups could be implemented in any school district as the curriculum would be good in schools. In that case, it was
suggested that school guidance personnel be approached for a focus group meeting. The
group anticipated “that schools would select their most troubled children.” It was offered
that a comparison of a control group and an experimental group would provide useful
data to schools and clinicians regarding trauma.

There was an exchange of techniques the therapists had used. They asked me
about adventure-based programming that the study group had experienced at Lakewood
Hospital when it was open. One clinician in the focus group said that he worked in a
wellness program on a university campus and used the adventure-based interventions
frequently for the purpose of developing group cohesion. I commented that Moonball,
which was used in the trauma curriculum, is one of those activities. One therapist who
worked with adolescents said they played Hang-On, a variation on Hang Man, using
trauma words the children learned in their group session. They also had a closure party, to
which I related, in that there was always such an event at New Directions in which the
children and adolescents received small gifts, including gel pens. Several of the therapists
in the focus group said that their child clients would do “anything” for a gel pen. The
others acknowledged this, laughingly.

The discussion then focused on helping clients to understand their anger. Several
therapists said that trauma groups they conducted validated their clients’ right “to get
angry,” yet provided hope that they would not re-experience abuse. The importance of
groups was reinforced since abused children are often “in group homes” or came from
“family systems where it was not OK or safe to talk about their experiences.”
These therapists indicated that “some of the adolescents report being bored, but eventually they get involved in the group process. . . . Just as you [referring to me] noted earlier, we also saw the teens start to support and help each other through some difficult issues.”

Discussion continued regarding things that might be changed. The writer shared the need to alter the way music was introduced to the adolescents to avoid a recurrence of a Dissociative episode that occurred in one of the groups. I also reported she would push the adolescents more. The group laughed in appreciation of working with that particular age group: “You mean you wouldn’t let them get away with so much?”

The group offered feedback concerning the organization and written presentation of the curriculum. They encouraged an expanded description of my rationale in going from one topic to another. They referred to this expanded description as an “advanced planner” so that the reader could envision what was coming next. The focus group added that the curriculum should also include a narrative summary. They described it as “a snapshot of where this [curriculum] is going.” They suggested several options, including “several pages explaining why a topic was selected in one order versus in a different order.” They offered that the curriculum “might have been the result of the natural flow of [my] work” and, by paying attention to where the children were and what was happening with them, I developed the curriculum.

Two experienced therapists spoke, finishing each other’s thoughts: “It [the curriculum] worked and it could have been very well intuitive. That you knew this is where you needed to start and this is where you needed to end. But, in reflection, you can
say this is why . . . it worked this way.” To say then “That is why the schedule works this way.” One of them continued to speak: “List all of those topics and do a reflection of the topics. They are all good. . . . They are important. Explain why.”

One of the members queried, “By experience did you decide to do anger before fear? Or, is it from your own experience from Lakewood that you sense it is easier for kids to get into anger before fear? You’re more empowered, in a stronger position, if you are angry than to confess you are afraid. That puts you in a more vulnerable place.”

Someone else offered a developmental thought: “Little children might be more comfortable with fear than with anger, whereas, with adolescents it might be reversed.”

Another individual offered that the curriculum was flexible, that it was “only a guide,” and that it could be adapted to the children with whom one is working. Another individual added: “You might have to trust the intuitiveness of the therapist in the room at the time with a particular group.”

Emerging Themes

Twenty-five themes emerged from the meeting with the study group. They included additional interventions, application of interventions, behavior problems, client growth, clinical experience, clinical growth, closure, cohesion, communication, culture, development, diagnosis/symptoms, disclosure, environment/structure, family systems, future research, intuitiveness, lack of training, process, repeating trauma groups, resistance, sensory, theoretical orientation, and transitional objects. The themes are listed in Table 6. A discussion of them follows.
Table 6

*Emerging Themes from Focus Group with Expert Practitioners*

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<tr>
<th>Emerging Themes</th>
<th>Additional Interventions</th>
<th>Application of Interventions</th>
<th>Behavior Problems</th>
<th>Boundaries</th>
<th>Client Growth</th>
<th>Clinical Experience</th>
<th>Clinical Growth</th>
<th>Closure</th>
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<td>Communication</td>
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*Additional interventions.* One of the experts discussed an exercise called Hang On, an adaptation of Hangman that uses trauma words in the activity. The therapist indicated it had been used with youth in another agency and was suggested for inclusion in the trauma curriculum.

*Application of interventions.* There was an inquiry about whether or not the clients in the partial practiced the exercises. One participant indicated such exercises were being sought. Another referred to the exercises as “good stuff.” Another individual indicated the exercises could be used with adult Dissociative clients. Another remarked, “There is some really good stuff in here, I was reading [the curriculum] and thinking of how it can fit with what we do.”
**Behavior.** In this thematic area, the participants discussed avoidance as characteristic of children and adolescents. They also referred to them as clingy and disorganized.

**Client growth.** The theme of client growth was mentioned in the group. A therapist commented, “it is validating to me to see kids do what you have shown them or to respond in a manner of change.”

**Clinical experience.** The therapists stated, in various ways, that my clinical experience influenced the curriculum. They cited examples of what I had offered, over time, within the study group.

**Clinical growth.** Clinical growth was another theme to emerge. It was tied to questions concerning child disclosures and the use of individual therapists.

**Closure.** Therapists in the study group who led adolescent trauma groups made a suggestion regarding the trauma curriculum. They suggested including a closure party during the last session held with either the children or the adolescents.

**Cohesion.** One focus group member discussed the use of adventure-based programming in order to build cohesion and indicated it causes a group to focus. One individual also asked a question regarding the manner in which peers responded to each other in the trauma groups.

**Communication.** The therapists addressed the importance of internal communication. They stated that staff not directly involved with the trauma groups should be made aware of needs of the children.
Culture. One therapist addressed the lifestyle lived by many of the children who are seen by therapists. It was put this way: “I have seen so many kids who do not have a normal life.”

Development. One member of the focus group stated that “children may be more comfortable with fear than anger, where with adolescents it might be reversed.” This statement lends itself to the theme of development.

Diagnosis/symptoms. Inquiries were made about various diagnoses including trauma, PTSD, Dissociative Disorders, and Reactive Attachment Disorders. Levels of dissociation were also discussed.

Disclosures. The therapists presumed that some disclosures would occur in the groups and were concerned how this was managed outside of the groups. They also asked if there was follow-up for those children who had disclosed. They were reassured that there was a system in place from the beginning for the client’s individual therapists within the partial program to be informed.

Environment/structure. Questions were raised about the “point system” discussed in the trauma curriculum. Someone asked if the therapists were included in the trauma groups. Another individual raised a question about the time frame of the trauma groups.

Family systems. There was some discussion in the study group about the environments, including group homes, in which the youth lived. One person said that in some home environments, there was no safe place in which they could talk about what they (the children) had experienced.
Future Research. One of the therapists offered: “It would be interesting to see the difference between normal kids who have not been traumatized vs. the group of traumatized adolescents.” Another offered that the school would be a good sight for future research for this study.

Intuitiveness. One of the focus group members stated, “You might have to trust the intuitiveness of the therapist in the room at the time with a particular group.” She continued along this line regarding the trauma curriculum and indicated that “it worked, and it could have been very well intuitive, that you knew that is where you needed to start and this is where you needed to end. But, in reflection, you can say this is why.”

Lack of training. This theme was epitomized by the statement: “It is just amazing to me the lack of understanding regarding trauma.” The study group members related that survivors with whom they worked often said that no one wanted to talk about what they (the adolescents) felt like after their traumas.

Process. The group asked about the process of disclosing during the groups. There was also a discussion regarding leadership to which I explained that the children demonstrated leadership in starting the three exercises with which each session was opened.

Repeating the trauma groups. One therapist questioned the effectiveness of clients rotating through the groups more than one time. Two therapists offered that their experience indicated that it was helpful and common to have the children repeat the groups.
Resistance. One individual who worked at a rape crisis agency said that their clients were reticent to participate in the groups until they had a sense of acceptance. One individual said that one of their adolescents “refused” to sign a group contract. The adolescent was not forced to do so, but he signed the form at the next group meeting.

Sensory. In discussing the exercises, group members made comments that indicated there was a great deal of movement and that the exercises were energetic. They asked if and how the children and adolescents were “settled” after performing the exercises.

Theoretical orientation. One person indicated the educational nature of the curriculum was reminiscent of Affective Education and Values Clarifications in the schools. Another said it would be “good” for schools. Several supported the expressive art aspect with the drawing and movement.

Transitional Objects. One therapist offered that children love pens and will “do anything” for one. This therapist worked at a facility that provided pens to their clients at the end of the groups.

Key Informant Interviews

Key Informant Interview with Outside Agency Representatives

The setting. The first of three key informant interviews occurred on March 16, 2003, at the administrative offices of the Fayette County Mental Health Mental Retardation located in Uniontown, Pennsylvania. Initially, I had intended to hold a focus group with representatives of outside agencies affiliated with New Directions. However,
only two individuals were present on the appointed day.\footnote{Other potential participants indicated they had other obligations.} Rather than forego the opportunity to meet with the two individuals, I decided to continue with the interview. Later, I discussed the situation with her dissertation chair, who advised that the interview could qualify as a key informant interview.

One of the two participants was directly involved with clinical behavioral health services to the youth of Fayette County through the Fayette County Mental Health Mental Retardation office. The other individual was affiliated with Health Choices, the agency which provides health insurance coverage for children in the county without private health insurance; he was a case management supervisor. Both individuals had lengthy experience in the behavioral health field. I had worked with both individuals relative to providing services to the children of Fayette County. In order to distinguish between the responses of these two informants, the representative from the Fayette County Mental Health Mental Retardation office will be designated by “MHMR.” The individual from Health Choices will be designed by “HC.”

The session. I began the interview by asking for their thoughts concerning the incorporation of the trauma curriculum at New Directions. HC indicated that “four years ago, I would say 40% [of the children in Fayette County whom they represent] had trauma issues along with their normal [primary] diagnosis. What I am seeing now is . . . closer to 70%.” He also indicated that identifying a “trauma history” in the children with whom his agency worked was “the norm.” He then stated, with great emphasis, that “there is a definite need” for service for the children. He added: “The kids are getting
younger and younger, and their issues are getting more and more complex.” He went on: “To meet the needs that all the kids have, there has to be more individualized treatment, and the trauma is the biggest piece . . . that I see.” MHMR agreed, particularly with the last few statements, and added: “It is being talked about. It is not being treated.”

HC went on, stating that there was “little one-to-one instruction going on.” He added: “There still is that conflict between professionals as to how you deal with it. I think that will always be there, because it is such a controversial subject when it comes to how you treat it [trauma].”

HC spoke specifically of New Directions, which he described as a “controlled setting.” He said that the children were in “an intensive treatment setting. What better place to address those issues?”

In speaking of the children at New Directions, MHMR indicated that a large number of the children there had “been abused in one way or another and have admitted it.” However, he added that a great many of the children “haven’t touched it yet.”

MHMR then went on to comment on the program. He said that the chief administrator of New Directions spoke “highly” of the way in which the trauma curriculum “turned out” when she discussed it with him. “She has tremendously good things to say not just about your treatment of he kids at the partial, but the trauma track that was established because she feels like it is giving her staff another tool to be used.” HC concurred and added that the staff had been provided with “a better awareness of what to look for and how to deal with it.”
MHMR added that therapists do not have much fundamental knowledge in trauma therapy. He added that, in his opinion, “it’s getting worse . . . certainly in Fayette County.” He stated that “young girls . . . almost expect to be abused in one way or another . . . They will accept a certain level of physical, sexual . . . abuse that . . . women in my generation would never have. It’s commonplace. I hear it all the time.”

HC added that he is “starting to see more and more victims becoming perpetrators. In their own household, siblings . . . turn on other siblings.” He indicated that in many families, an older sibling who was a victim becomes a perpetrator “. . . like it’s being passed down from one sibling to the next and unless there is something initiated to address this and help these kids deal with it, I don’t see it stopping. It’s a big concern and I think that’s why there has been such a big spike in our percentages over the last four years” concerning the number of individuals with abuse issues.

When asked about some of their frustrations, HC firmly responded: “I can speak of my own experience. I manage all the RTF [Residential Treatment Facility] kids in Fayette County, and the trouble I have with all, with a lot of the RTF facilities is that they do not have a specialist available on their staff, or they don’t have the resources available without contracting . . . someone . . . to come in to deal with the kids trauma issues. And, as with the New Directions Program, the percentages are the same with the RTF kids . . . 70% are carrying trauma abuse issues of some type . . . with them and that is creating a whole different realm of treatment modality that these kids require while they are in treatment.” MHMR added that what they hear from the RTFs is “‘We are dealing with that and we can take care of that.’” Both individuals said that statement is not
accurate; however, if they question the RTFs regarding specialized training and their
treatment plans, the RTFs do not respond, and, while abuse is being discussed, it is not
being treated. They reported that the RTF representatives will often say they do not want
to “stir things up” or they will respond that dealing with abuse “is for a specialist to do.”
They agreed that combined symptoms of nightmares, enuresis, encopresis, sexual
misconduct, teenage promiscuity, and total isolation, all of which are known red flags to
assess further for maltreatment, “seem to be ignored at times.” “It is almost like they want
to play ostrich and stick their head in the sand and hope these signals go away, and we all
know that doesn’t happen.”

Another area of concern is the mentally retarded clients who are victims and also a
perpetrator. How to treat such an individual is challenging because this population has
difficulty in understanding certain concepts. Getting treatment molded to the needs of a
client so that the client can respond is difficult. HC put it this way: “Being a trauma
therapist is one thing. But, when the client does not have the cognitive abilities to grasp it
[the treatment], how do you reach them?” MHMR felt that the sensory approach of the
curriculum might be effective.

“Since both of you have noted an increase in the number of youth with trauma
histories over the last four years,” I stated, “has it changed your view of trauma in
relationship to the youth you service? Have you found yourselves asking different kinds
of questions of the families and children you see?” One commented: “The way that you

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6 Involuntary urination.

7 Involuntary soiling
define what may be traumatic has changed for me. I have an increased awareness of the way to ask the questions and . . . I am probably much more delicate about it in a lot of ways than I ever was before.” Both individuals made it clear that when they meet with families they do not ask in-depth, probing questions, rather they just ask enough to obtain the information necessary to either authorize an increase in the level of care or connect the client with needed services.

Both men indicated there were times when they had been “taken back” by responses to a question, particularly one regarding child abuse. “You ask: ‘Did you know this was going on?’ and the parent looks you straight in the eye and says ‘Yes.’ And, with further questioning, it is learned that the abuse has been occurring for years and that it is generational. This goes on routinely in some family systems and the parents cannot comprehend the negative impact that’s added onto children.”

Both individuals agreed that an important question they must ask is: “Who is the parent?” They said one needs to know if the person with whom they are speaking is the parent, the grandparent, the stepparent, the foster parent, the adopted parent, or CYS [Children and Youth Services]. “Just being able to identify who is the parent sometimes is the biggest struggle.” This guides who they interact with, the perception of the child, and the services that are provided. Through experience, they have learned that CYS is often the custodial parent. It creates a challenge–how do you involve them, and who else should be involved? “You have to ask: ‘Who is the parent? And, where is Johnny going to go eventually?’”
When asked what, if anything, about the curriculum was of interest to them, MHMR said that “one of the beauties of the way you guys structured it . . . is the rotational nature. . . . So, it’s like [a] train the trainer kind of model . . . it perpetuates itself so it does not end when Barb Peck isn’t there anymore. So that’s been one of its high points as far as I’m concerned.” Both participants indicated that the partial is difficult to work in because of the kind of kids the chief administrator will take, and because she wants the support to deal with those children.

They presented that the trauma focus is an additional tool for the staff to use and should help to improve the staff’s awareness in the assessment and treatment of the children and adolescents. They also said that the trauma curriculum and training sessions should increase the staff’s level of confidence and their ability to treat trauma issues. They said that implementing the curriculum was “a good move on the part of you and the partial as a group to institute what you did.”

Both individuals had some concerns. “What happens when you are not there as a catalyst to keep the program going?” They wanted to know if the staff had enough training and the willingness to keep it going. I explained the agreement she had with the staff.

They presented concerns about increasing the involvement of the family members, recognizing that transportation is a major problem for families in this area, and the possible resistance to participate in such a group. They also offered that research done with RTFs indicated that the more families are engaged, the greater the percentage of
success for the child following her or his discharge. They also likened their experiences of family involvement to “pulling teeth.”

Vicarious trauma was an issue raised since both key informants were aware of the intensity of treatment, on a daily basis, at the partial program. They were both cognizant of the staff’s need to be “on their toes” and anticipate that clients might try to run away, fight with others in the program, or erupt emotionally. “There is no room for downtime.” One of the informants acknowledged that, early in his career, he experienced vicarious trauma, although he did not know then that there was a name for it. The informants also addressed the management of the children following a trauma group session and were concerned about the session disrupting the rest of the program or day.

When asked what they would change in the trauma curriculum, they encouraged individual work to complement the groups. [I indicated that the children have one-on-one sessions with therapists.] They then suggested that I sit in on individual sessions in order to guide and support the therapist.

When asked if they had any other concerns, both participants indicated a noticeable surge of adoptive parents terminating adoptions, primarily due to the aftereffects of traumas sustained by the children but unknown by the adopting families at the time of adoption. These families reported being unprepared and, therefore, unable to manage their adopted children. MHMR commented that this situation had the “potential to re-traumatize the children” and, if prior attachment issues existed, the children were once again being abandoned and attachment issues could recur. He went on to say that this issue was more difficult with children who were also mentally retarded.
The two informants went on to discuss families. Young parents, they indicated, were also a challenge since they could not always grasp, in a cognitive sense, what they needed to do. They indicated that young parents appear to have problems “structuring the home environment” and needed support in the form of suggestions for managing their homes.

**Emerging Themes**

Eighteen themes emerged from this interview with the two key informants. The themes were as follows: additional interventions, behavior problems, clinical experience, clinical growth, communication, culture, development, diagnosis/symptoms, environment/structure, family systems, lack of training, organization, parental involvement, poverty, sensory, support for trauma groups, theoretical orientation, and vicarious trauma. The themes are listed in Table 7. A discussion of these themes follows.

**Table 7**

**Emerging Themes from Key Informant Interview with Health Choices and Mental Health/Mental Retardation Representatives**

<table>
<thead>
<tr>
<th>Emerging Themes</th>
<th>Additional Interventions</th>
<th>Behavior Problems</th>
<th>Clinical Experience</th>
<th>Clinical Growth</th>
<th>Communication</th>
<th>Culture</th>
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<tr>
<td>Parental Involvement</td>
<td>Development</td>
<td>Diagnosis/Symptoms</td>
<td>Environment/Structure</td>
<td>Family Systems</td>
<td>Lack of Training</td>
<td>Organization</td>
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<td>Poverty</td>
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<td>Vicarious Trauma</td>
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<td>Sensory</td>
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<td>Theoretical Orientation</td>
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<td>Vicarious Trauma</td>
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Additional interventions. Both individuals suggested an intervention to complement the trauma groups. They encouraged the incorporation of family groups at the partial program.

Behavior problems. Both individuals reported seeing an increase in the occurrence of sibling abuse. They reported that behavior problems often bring children to their attention professionally.

Clinical experience. They both concurred that an important and essential question they must always ask is: “Who is the parent?” They indicated they must always clarify the relationship of the person with whom they are speaking and identify the individual as the parent, grandparent, stepparent, foster parent, adopted parent, or as CYS [Children and Youth Services]. They talked about this seemingly simple task as difficult: “Just being able to identify who is the parent sometimes is the biggest struggle.” The issue is important in that it guides several issues including the person with whom they interact, the perceptions of the child, and the services that are provided.

Clinical growth. Both participants identified the trauma groups as an “additional tool” for the staff to use. They said the groups would improve the staff’s awareness and treatment of trauma and increase their level of confidence. MHMR stated that his definition of trauma had changed, contributing to an increased awareness of the way in which he asks questions. “I am more delicate . . . than I ever was before.”

Communication. The issue of communication, as discussed by these key informants, involved their communication with families. They talked about asking
questions in order to get the information needed to authorize care or to refer a client to other resources.

*Culture.* Both participants addressed the culture of Fayette County. Each of them discussed an increase in the number of adoptive parents terminating adoptions. They indicated this was primarily due to the aftereffects of traumas that had been sustained by the children but unknown by the adopting families at the time of adoption. These families reported being unprepared and, therefore, unable to manage their adopted children. They also indicated that young parents appeared to have problems “structuring the home environment” and needed support and suggestions to better manage their homes.

*Development.* The two key informants identified another area of concern, “the mentally retarded client who is a victim and also a perpetrator.” They voiced concern regarding the treatment of such an individual and cited the treatment as “challenging” since this particular population has difficulty in understanding certain concepts. As one of the individuals put it, “Getting treatment molded to the needs of a client so that the client can respond is difficult.”

*Diagnosis/symptoms.* The informants discussed various symptoms including nightmares, enuresis, encopresis, and sexual misconduct in which the teenagers engaged. They also discussed the fact that trauma effects could be labeled as Conduct Disorder or Oppositional Defiant Disorder.

*Environment/structure.* Both individuals stated that the staff at the partial needed to be “on their toes” most of the time. In comparing the partial with RTFs, they said that
the latter did not have a trauma specialist on their staff nor did they have outside resources available to them.

*Family systems.* The informants were “taken back” by the responses of parents who, when asked if they were aware of their child’s abuse, said “Yes.” Both individuals said that “abuse [had] been occurring for years and that it [was] generational,” occurring routinely in some family systems. They added that some parents could not comprehend the negative impact abuse had on children. They also indicated that young parents appeared to have problems “structuring the home environment” and needed support in the form of suggestions for managing their homes.

*Lack of training.* MHMR commented that, in general, therapists do not have much fundamental knowledge in trauma therapy. He said the reason for this situation is the lack of its inclusion in pre-service training institutions.

*Organization.* It was reported in the interview that the implementation of the trauma curriculum was a “good idea” for New Directions. Both interviewees agreed there was a need for such a curriculum.

*Parental involvement.* The informants discussed the involvement of family members but also recognized that transportation is a major problem for families in this area. They indicated that transportation is, possibly, the reason for the resistance by parents to participate in group meetings. They also offered that research done with RTFs indicated that the more families are engaged, the greater the percentage of success for the child following her/his discharge. They also likened their experiences of family involvement to “pulling teeth.”
Poverty. In remarking on the traumatic experiences youth in Fayette County have, one of the key informants said “tackling this type of issue in a county setting such as Fayette, it’s overwhelming, because it’s just not treating the kids. You have to overcome the environmental issues, the lack of work, the poverty.” He went on to say that transportation is a big issue for families.

Sensory. MHMR commented on the sensory approach taken in the curriculum. He said he felt that the sensory approach of the curriculum might be effective “in reaching those clients who do not have the cognitive abilities to grasp it [treatment].”

Support for trauma groups. Support for the continuation of the trauma groups was made by HC. He said that the partial is “a controlled . . . intensive treatment setting” and asked “what better place to address these issues?”

Theoretical orientation. HC noted that conflict exists between professionals regarding how one treats trauma. He said that it was a controversial subject. MHMR said he appreciated the concept and process of “training the trainer” that is included in the implementation of the trauma curriculum.

Vicarious trauma. Both participants voiced concern about vicarious trauma as it applied to the staff at New Directions. Their reason for mentioning it was the intensity of treatment provided at New Directions and the many needs of the children. They were aware that there was “little down time” for staff due to the nature of the program.

Key Informant Interview with Psychiatric Nurse at New Directions

The setting. The interview with the psychiatric nurse occurred twice due to technical problems but was successfully accomplished in the library at New Directions on
March 24, 2003. The nurse, who had been employed with New Directions for 33 months, had just completed a master’s degree as a nurse practitioner. She worked closely with the staff and administered all daytime medication to the children who required it, assessed physical complaints, and debriefed both the children and staff following restraints. Although she was not an active participant in the trauma groups, she attended them on a regular basis and was attentive and inquisitive during the consultation time. She engaged easily and was not at a loss for words. She enthusiastically responded to questions and expanded on her thoughts without prompting from me.

The session. I asked her thoughts regarding the effects of the trauma groups at New Directions. The nurse said “the entire program has definitely benefitted” from including the trauma curriculum. She added: “Not only the clients but the staff as well.” She indicated that, prior to the curriculum being implemented, most of the therapy was behavior-oriented and “getting to the actual core of the issues” was a “taboo.” Even the therapists were “very uncomfortable” when a child or adolescent disclosed a trauma issue. “They didn’t have a lot of experience prior to coming here to the program,” and they “weren’t sure how to follow-up with it or even how to start . . . addressing” the problem. “But, when we started these trauma groups, trauma was no longer the taboo that it once was . . . with the clients and the staff alike.” She added: “Just last week, there were three different kids who very openly and honestly talked about their trauma to a therapist.” She indicated that had not been the norm for the two prior years. She said that the children disclosed because of the trust and support they had gained through the trauma groups.
“Through the [trauma] trainings,” she said. “The staff operate from that perspective now and it’s important because I believe that 90% or more of the clients here have gone through trauma, have experienced trauma in their lives, and that is . . . the root of the [behavior] problems and relationships.” But, “they’re finally getting to the source instead of just working on the outside of the problem, really getting to the core of the problem.” . . . “I believe truly that the program, the clients, and the staff, as a whole, have benefitted.”

The nurse indicated that a great many of the children and adolescents receiving service at the partial had experienced trauma at one time or another. “I read the charts. I’ve seen the psychiatrists. It is hard for me to even come up with . . . eight names of clients who have not experienced [some sort of] trauma.”

I indicated that the children and adolescents consistently performed three exercises in their trauma groups and asked if the nurse was familiar with them. “I’m very familiar with the exercises the kids do, only because I see kids doing [them] and I hear kids talking about [them].” She said she saw the children perform the exercises at various times during the day, including when they were standing in line or in their classrooms. She indicated hearing children talking about the Pretzel and Butterfly Hugs. “. . . you’re giving them all the skills that they need in order to use the different tools and . . . they can tell you ‘I do feel more calm,’ ‘I do feel better,’ ‘It does help me to relax.’ You’re giving them . . . new things that they can do and it given them control over their feelings, over their emotions.” She was also very aware that the exercises were connected to the right
and left brain theory as it relates to trauma. She said: “... through research ... trauma does make neurological changes in the brain.”

She also explained that the children have journals in which the therapists correspond with the parents. Some of the children had informed their parents of the exercises and the parents “say that the child showed them what the Pretzel is and why it helps them.” “True story,” she added for emphasis.

When asked what she would change in the program, “I think the only thing that I would change is to make sure that all the staff got to rotate through and all the clients that were ‘ready’ to participate ... would all have a chance ... I think that what we have is wonderful. ... I see it working every day ... and I am here eight hours a day, five days a week.”

She indicated that I should provide “more” educational opportunities, particularly concerning vicarious trauma. She indicated that staff members are exposed to overwhelming situations on a daily basis. “Had you never addressed this with us, we never would have realized what does happen.” She went on to say that she often does not know what to do with some of the feelings she has as a result of working at the partial hospitalization program. She added that I did not “give us false hope, and you don’t tell us that this is your answer for everything ... but you always present new ideas.”

When asked if your concept of trauma had changed due to inclusion of the trauma groups, the nurse responded “Oh, my, yes. From a nursing perspective, I can tell you I heard something I did not realize before, and I started to pay closer attention to the kids and their response to the medications. I did not know repeated exposure to traumatic
events can have a long-term effect, with symptoms that looks like ADHD. I do not think we have too many cases of only ADHD, and I have seen a few children not improve on any stimulant, and you suggested to assess further and ask more questions, as there could be past traumatic experiences or family history of undiagnosed mental health problems. Also, the profound impact of early trauma on development . . . I just did not realize the paths traumatic events can have.”

Because Fayette County is a rural area, I asked if the nurse saw poverty as a factor. She said that she perceived poverty as a “cyclical relationship” in that poverty leads to low educational levels in adults, which, in turn, generates large number of children from low-income families. These issues, coupled with “generational mental health issues, generational conduct problems, and generational substance abuse” feed off one another. “I think that the poverty aspect definitely, without a doubt in my mind, impacts why these children have issues.” She went on: “Without having that social support, without having finances, without having a car to take your child to an appointment, without education . . . some parents with middle school education [with] only so many skills to fall back on, it definitely impacts the children . . . they see no way out. They don’t see that things can be different. They don’t know any other way.” The nurse discussed the transportation problem in many Fayette County families and said, “A lot of kids here have not left this county. You take them into ‘Pittsburghland,’ it’s like taking them into New York City. That’s what it’s like. Without the financing, without the support from your community, you’re going to continue to keep those people ‘down’ and you’re going to
have that relationship continue . . . the poverty . . . the low education . . . the mental health problems. They are going to feed off one another.”

To support some of her thinking, she said: “I can . . . probably count on one hand the number of clients [who] pay for their lunch. The majority of them, through papers that their parents fill out and send into the school districts, are eligible for free lunches, and that is all income-based.” She then referred to the situation as a “risk factor.”

When asked if she would like to add anything else, the nurse offered that the partial program works with seven school districts in the area and called them the partial’s biggest referral source. She indicated that students are usually referred to the program due to behavioral problems. Other referral sources include therapists, ICM (Intensive Case Manager) workers, and parents. “Recently, . . . we have parents calling out of the blue and asking about our program. . . . It is very rare that we run low on referrals.” She said that most of the children have been in treatment before they arrive at New Directions, and there are children as young as five years of age in the program. “We’ve seen a big burst of young, young clients coming to New Directions. We have an entire group full of them. . . . We’re not sure what that’s about.”

I asked the nurse about the bell choir she began. Enthusiastically, she described what had happened. “I originally had the idea because I work with them in the church. These are hand bells that require no more skill than knowing your primary colors, and it does require a leader [who] has color coded cards they hold up for so many beats to a taped song.” She described that each player holds a bell in each hand. When the choir
director held a color-coded card for the children to see, those children with bells of the same color rang their bells.

The nurse continued: “I really didn’t think much about it until we started learning from you about the right [and] left brain connection with trauma and how it is so important to utilize both sides of the brain when it comes to treatment. . . . Through your training, I had the idea about the bells.” She went on: “One bell [is] in the right hand and one [is] in the left hand, which does require you to use both sides of your brain at the same time. Plus, it uses your visual sense and your auditory sense all at the same time. So, you’re using all of these different senses on both the right . . . and left side of the brain. Plus, it’s music and I think music plays a very important role not only in our lives but it can also be used as a very good treatment modality for certain problems.”

She presented the idea to the program director and was able to purchase the bells and music. She felt supported by the staff in this endeavor. Next, she did a trial run with a group of pre-adolescent males whom she thought it would be difficult to work. Initially, the boys were resistant: “‘. . . this is dumb, this is stupid, I’m in a bad mood, I don’t want to do this.’” However, when they had completed the task, they were smiling, not laughing, and proud of their accomplishment. She said: “I saw their moods improve and I saw the smiles on their faces.” She noted that before the children played the bells, she had them do the Brain Gym® exercises, explaining to them it was to “make sure that our brains are working well.”

She went on: “Had it not been for the trainings, had I not been aware of right brain/left brain, had I not been aware of theories, just a little bit of theory behind the
EMDR, that [the exercises] never would have made sense to me. And,” she added, “I think the program would have missed out a bit.”

The nurse explained that the bell choir was made available to all the children and adolescents at New Directions. Eventually, they went out into the community and played at nursing homes and for all the agencies located in the Uniontown Health Center. Each of the Bell Choir’s performances was preceded by the Brain Gym® exercises. The nurse reminded me that these children were referred to New Directions for behavior problems. The Bell Choir performed as part of the holiday program at New Directions.8

**Emerging Themes**

Twenty-two themes emerged from the one-on-one key informant interview with the psychiatric nurse at New Directions. These themes included additional interventions, application of interventions, behavior problems, client growth, clinical growth, communication, culture, development, diagnosis/symptoms, disclosure, empathy, family systems, lack of training, organization, poverty, process, resistance, sensory, support for trauma groups, theoretical orientation, and vicarious trauma. Table 8 contains a list of these themes. They are discussed below.

**Additional interventions.** When asked for input regarding the trauma curriculum, the nurse indicated that I should provide additional educational opportunities for the staff. Although this suggestion did not relate directly to the children and adolescents, it would affect them indirectly.

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8 What the nurse did not disclose was that she made green and red ribbons and supplied Santa hats for each of the bell ringers. She also made sure every child had a white buttoned shirt or blouse to wear as part of their costume.
Table 8

*Emerging Themes from Key Informant Interview with Psychiatric Nurse at New Directions*

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<thead>
<tr>
<th>Emerging Themes</th>
<th>Additional Interventions</th>
<th>Application of Interventions</th>
<th>Behavior Problems</th>
<th>Client Growth</th>
<th>Clinical Growth</th>
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*Application of interventions.* The nurse reported seeing the students performing the sensory exercises outside the trauma groups, particularly in the halls and in the classrooms. Two of the exercises she recognized were the Pretzel and Butterfly Hugs. She noted that she instructed the children in performing the Brain Gym® exercises before playing the bells, explaining to them it was to “make sure that our brains are working well.”

*Behavior problems.* The nurse stated that the children had been referred to New Directions for behavior problems. She also expressed her surprise at the manner in which the children adapted to the Bell Choir, particularly because of their behavior health issues.

*Client growth.* The nurse indicated seeing growth in the children at New Directions. “Just last week, there were three different kids who very openly and honestly
talked about their trauma to a therapist.” The nurse reported that some of the children had told her, “‘I do feel more calm,’ ‘I do feel better,’ ‘It does help me to relax.’”

**Clinical growth.** One example of this is the nurse’s ability to use the theory of full brain activities in initiating the Bell Choir. The nurse commented, “I see the staff getting to the core of the problems now,” in reference to the clinicians having participated in the trauma groups. She reported learning about “the profound impact of early trauma on development” and said she did not “realize the paths traumatic events can have.” She also stated that she was not aware of the long-term effects caused by repeated exposure to traumatic events.

**Communication.** One of the themes that emerged from the conversation with the nurse was that of communication. She explained that the children had journals in which the therapists corresponded with the parents.

**Culture.** The nurse said she perceived poverty as a “cyclical relationship” in that poverty leads to low educational levels in adults, which, in turn, generates large numbers of children from low-income families. She said these issues, coupled with “generational mental health issues, generational conduct problems, and generational substance abuse,” fed off one another.

**Development.** The nurse commented that children as young as five years of age were in the program: “We’ve seen a big burst of young, young clients coming to New Directions. We have an entire group full of them. . . . We’re not sure what that’s about.”

**Diagnosis/symptoms.** In discussing the diagnoses of the children, the nurse reported not believing the number of diagnosed cases of ADHD was correct. She reported
seeing only a few children improve after taking a stimulant (a remedy for ADHD) and suggested further assessment because she believed past traumatic experiences and family histories of undiagnosed mental health problems would be discovered.

Disclosure. She commented on disclosures made by students: “Just last week, there were three different kids who very openly and honestly talked about their trauma to a therapist.” She indicated that had not been the norm for two prior years. She said that the children disclosed as a result of the trust and support they had gained through their experiences in the trauma groups.

Empathy. This theme was evidenced by the concern the nurse expressed for the families and children living in poverty. She spoke of the need for further resources. It was also demonstrated by her efforts to initiate the bell choir for the children.

Environment/structure. The nurse spoke of the referral base of New Directions indicating that the partial program works with seven school districts in the area. She said they were the partial’s “biggest referral source.” She also stated that “the entire program has definitely benefitted . . . the clients and staff” by including the trauma curriculum.

Family systems. The nurse recognized problems experienced by the families of the children at New Directions: “Without having that social support, without having finances, without having a car to take your child to an appointment, without education . . . some parents with middle school education [with] only so many skills to fall back on, it definitely impacts the children . . . they see no way out. They don’t see that things can be different. They don’t know any other way.”
Lack of training. The nurse commented that the therapists were “very uncomfortable” when a child or adolescent disclosed a trauma issue. “They didn’t have a lot of experience prior to coming here to the program,” and they “weren’t sure how to follow-up with it or even how to start . . . addressing” the problem. She acknowledged not realizing the extent to which trauma affected the development of children.

Organization. She reported support from the staff in creating the Bell Choir. She presented the idea to the program director and was able to purchase the bells and music. In another part of the conversation, the nurse discussed referrals made by school districts, ICMs, therapists, and families. She also said the entire program benefitted from the trauma program.

Poverty. She said that the prevalence of poverty among the children at New Directions was supported by the number of clients eligible for free lunches. The nurse empathized “Without having that social support, without having finances, without having a car to take your child to an appointment, without education . . . some parents with middle school education [with] only so many skills to fall back on, it definitely impacts the children . . . they see no way out. They don’t see that things can be different. They don’t know any other way.” She continued, “I think that the poverty aspect definitely, without a doubt in my mind, impacts why these children have issues.”

Process. The nurse explained that the Bell Choir was made available to all the children and adolescents at New Directions. Eventually, they went out into the community and played at nursing homes and for the agencies located in the Uniontown Health Center. In reference to the inclusion of the trauma groups, she added, “they’re
finally getting to the source instead of just working on the outside of the problem, really
getting to the core of the problem.”

*Resistance.* She commented that the boys were resistant when first introduced to
the Bell Choir. They made comments such as “This is dumb,” “This is stupid,” and “I
don’t want to do this.”

*Sensory.* She spoke of the sensory involvement with the Bell Choir. Students were
required to use both sides of their brains with one bell in the right hand and one in the left
hand. She also commented on their use of their visual and auditory senses.

*Support for trauma groups.* The nurse supported the inclusion of the trauma
curriculum at New Directions. She said that “the entire program has definitely benefitted”
from including the trauma curriculum. She said that not only the children and adolescents
benefitted, “but the staff as well.”

*Theoretical orientation.* The nurse alluded to theoretical information she had that
helped her appreciate the right brain/left brain aspects of the trauma group exercises. She
also indicated that prior to the introduction of the sensory exercises, most of the therapy
at New Directions was behavior-oriented.

*Vicarious trauma.* The nurse indicated that staff members were exposed to
overwhelming situations on a daily basis. “Had you [referring to me] never addressed this
with us, we never would have realized what does happen.” She went on to say that she
often does not know what to do with some of the feelings she has as a result of working at
the partial hospitalization program.
Key Informant Interview with the Medical Director at New Directions

The setting. I met with the medical director of New Directions on Friday, April 25, 2003 in a room designated for meetings. The room was painted white, and, because it was sunny, no lights were needed. Located next to the main office, the outside noise was minimal. We sat at a table across from each other. The room contained some amenities for use by the staff.

The session. I began the meeting by commenting on the medical director’s role at New Directions. She began: “It’s kind of like we are thrown back 40 years ago when the community mental health system first started . . . The psychiatrist was the director of the mental health center, and, then . . . as financial pressures came along, it was more economical to hire someone at the Master’s level to be the business administrator and the psychiatrist was moved to the position of medical director and doing clinical work.”

In discussing her career, the medical director said she had worked in several outpatient settings, at least one inpatient unit, and at another partial hospitalization program. She said she favored the partial setting and explained that it is the place where the time spent with a child and the family is concentrated, the therapeutic approach is more intense, and there is a better use of time. Additionally, the agency can make referrals as needed. She commented that results are also more readily seen in the partial hospitalization setting because of the frequency and intensity of the therapy that occurs.

The medical director said that the partial is a place “where you can apply . . . therapy for a child and their family” and “see results . . . in a time frame that . . . is more acceptable.” She indicated that was not the case in outpatient therapy
because major changes could not be seen in a short period of time. In partial, however, “because of the intensity of the treatment, because we require the families to be involved, and because we also refer freely to other services that can go into the home and be involved in what we are doing,” changes occur “more rapidly.” She went on to say “it is kind of a pay back. If I can see that . . . in this work I get them better, then I’m going to continue to put in the work.”

Discussion continued concerning her idea of creating a trauma curriculum at New Directions. She offered that it was an “old concern” of hers. “I worked for aftercare in Pittsburgh . . . at an approved private school with a partial. At the beginning of year, we would . . . unofficially poll the students on the children’s unit, some 50 kids . . . half of them would come with a known trauma history. . . . At the end of the year, it would be more like 90%. Eventually, it got to be 100% of the kids . . . had a trauma history.” When she came to Fayette County, “sadly, we repeated the statistics from when I was in Pittsburgh. You knew that half of the kids [had] a trauma history. As the year went by, we found another 25 or 30 that had a definite trauma or enough evidence from their behavior and history that there was a trauma,” but they had not presented it. Even with the three partials,9 there was a survivor’s group, but “there was no intensive training of the staff.” She proceeded to say that “nobody was really doing anything specifically to address that.”

When New Directions started in 1999, the intent was “to train the staff to be aware of the reactions in the children that could be a sign there was [a] trauma history.”

9 She is referring to the elementary, middle, and high school programs at New Directions.
She also knew, by the nature of academia, that regardless of the therapists’ educational backgrounds—counseling, social work, or psychology—they “really don’t have an extensive knowledge of trauma and how trauma presents itself in children aged 5 to 18.”

Additionally, she that one would assume that students would be properly trained. However, “when they come to practice [their skills], they lack a lot of the mechanics. You know, they know the theory, but they do not know ‘How do I get this topic brought out?’ or ‘If this is something else, where do I go with it?’ Of course, we had an expert—that was you [referring to me]—to come and have one of my therapists co-lead therapy group so that they learned those skills. I had you come . . . to do training so that they knew.”

I asked the medical director her sense of the staff’s ability to assess the children after more than one year following the initiation of the groups. The medical director said that she sees the staff as “more spontaneous” and willing to present a child’s symptoms, including dissociation. “It [the trauma groups and training] has allayed their suspicions and their capability of seeing a child having the signs of a trauma. And, then, trying to get the child . . . to come forth with the information and process it.” Regarding her awareness of the increase in her staffs’ skills, she said: “I see that they have more skills. I see them applying a greater number of skills, . . . and I think that is what they are getting through the training. They now have some clinical pathways to follow. [The staff] knows more [in order] to ask this kind of question or maybe engage in this kind of play or . . . activity. It allows them to tell you more. . . . I see them [the staff] knowing more about the problems that the children have . . . and now know what to do with that information better then what they used to know.”
The medical director went on to discuss a new therapist and said she makes it clear, even though it may sound harsh, that learning about boundaries is essential and stresses that the therapists must communicate this message to their clients: “‘I am not your friend, and I am not here to be your friend. I’m your therapist. I am here to be the instrument of you getting better. I may not make you totally better, but I am the stepping stone to your recovery.’ That is the hard part, because, at times, the therapist will think ‘that kid left and I didn't do much for him.’ Well, maybe this was a time when they could only make a small [amount of] progress.” She said she also assured her staff that some children return several times and, each time, improve in some area.

She continued to say that “non-therapeutic staff and the teaching staff function as therapeutic [staff] here. But, if someone comes to [the] partial, [they] may not get the impression that staff [other than the therapists] come forward [with concerns].” She provided a scenario: Teachers have come to her and said “‘You know it seems like every time I move in a certain way, this child does this, or, sometimes, they just space out, and I don’t know where they are.’ [and I say] ‘You know they are dissociating like you heard about in our training.’” She presented that “Everybody has a higher IQ here on trauma, which is good, because we don’t miss it [the trauma diagnosis].”

The medical director also addressed the inpatient assessments done on children. “We have children [who] are actually hospitalized several times, and the physician at the hospital never uncovers the trauma, and, through treatment here, we uncover the trauma. . . . That makes sense instead of several hospitalizations.”
I explored her thoughts about the sensory motor and movement emphasis in the trauma curriculum. She remarked that “the whole field of trauma has to be creative. . . . We have been all the things we knew for years [were trauma related], but we have not been getting the best results. So, something different than what we have been using has to come along.” She observed that the children who had been through the trauma groups have applied what they learned in the groups when confronted with stressors in other areas “totally unrelated to their trauma history. They use techniques that they have been taught.”

She indicated that, in the monthly parent meetings, “parents have asked about the Pretzel thing” their children are doing. “We [the staff] trained the parents one evening on what the Pretzel was and how to use it. We have gotten feedback from a couple of those parents on how they are now using the Pretzel technique because it helps them [their children] feel better and more relaxed. The parents know how it works and have a better understanding. They encourage them [their children] to use it when they see their child getting upset or anxious. So, I think that it is really amazing how much improvement some of the kids get with it.”

The medical director spoke of the effects of the trauma groups: “Probably the one child who had the most improvement was a female who has now been in our program for the past three years, and it was extremely stormy when she went through the trauma group. Since that time, she has made much more progress in the year since her first trip through trauma track than she made through the first two years in the program, because, clearly, she wasn't getting what she needed. Once she went through the trauma groups and
learned some of those skills and did some processing, . . . she has been able to make remarkable progress and has been able to control her anger and her emotional outbursts.”

The medical director recalled a situation that occurred a week before our interview in which the same student handled a problem that, in the past, would have led to a restraint and would have gone on for hours. The client was upset because her ICM [Intensive Case Manager] wanted to take her out of the program during a school day in order to attend a ball game. The ICM was told by the medical director that it was not appropriate to do that on a school day. Unknown to the client, arrangements had been made with the ICM to go to the ball game on a non-school day. The client thought she was not allowed to attend the ball game on any day. Instead of “having the usual blowup,” the client went to her therapist and said she needed to discuss something with her. It was two hours before the therapist could meet with her. The client told her therapist that it was not “fair” that the outing had been taken from her, because she would not get to go to a ball game unless she was accompanied by her ICM. The medical director described the client’s behavior as “very proper.” When the client was told she would be going to a ball game, however, it would not be on a school day, “it was amazing to see her transition.”

She also addressed the use of restraints and how the groups played a part in this issue. “We track restraints on daily, monthly, and yearly bases. After the completion of the first section of trauma groups, we had a major spike in our restraint [use] from a few of the kids [who] had been in the first section of the trauma groups. On review, we contributed that to the fact the process of going through the sessions opened up many issues that couldn’t possibly be dealt with in the first sessions and had to be ongoing.”
She indicated that the problems were “primarily with the adolescents and one person was transitioning to the adolescent unit at the time. . . . If you look at the history of the one adolescent responsible for the spikes, considering the number of restraints required in the first four months of treatment compared to the number following her trauma group experience, it still was not as high as it [had been] initially. I think it [the trauma group] helped her modulate her outbursts so she did not have as many as she did before being in trauma.”

I then asked the medical director about future changes or additions to the program. After a few moments of thought, she discussed different models and theories she planned to introduce to the program: “I think, more or less, just bringing in some different models and different theories, some of the things we talked about, what Stanley Greenspan called ‘floor timing,’ where he says that children, for a variety of reasons, have their development disrupted or sidetracked, and they don't complete a developmental circle.” She went on, “I think that the traumas prevent them [the clients] from closing developmental circles, and I would really like to see a combination of what we have been doing [combined] with Stanley Greenspan’s techniques. . . . As we work on trauma, the child could then enter a . . . therapy session aimed at completing the developmental cycle. With the help of the parent and the staff, we could help that child complete that developmental path and move on. The interesting thing . . . when these kids are going through trauma track, and they get upset, and they get restrained, they revert, I believe, exactly where the trauma happened and where the development has been arrested. So often, it is like two or three year olds with temper tantrums. It is crying. It’s being in
control, and it’s thumb sucking. It makes you know that they still do not have all the complete developmental circles. So, we are considering taking a couple of staff who are developing good skills with dealing with the trauma and having them trained with Stanley Greenspan on the floor timing. [Then,] we could combine the two.”

She further explained: “What the concept encourages in doing a developmental assessment is to determine what path the child hasn't completed. . . . Then, what you do as a therapist is prescribe play activities primarily for the families to do with the child to help them complete the development.” She presented an example. The therapist would “tell the parents that they may have to play Barbie's with the children . . . for half an hour, and the parent needs to be directed to be the subordinate person and allow the child to develop the entire scenario. Ideally, the therapist does this with a one-way glass and observes the process. And, you are probably going to find out why that child did not complete that circle.”

In one training session, the medical director explained that a mother was instructed to be subordinate to her child. “It wasn't thirty seconds into the play that she [the mother] was telling [her child] ‘Well, no, I don't think the blond hair doll should be with the male with blond hair. I think brunette with a blonde.’ . . . She [the mother] was controlling the whole play scenario with the child. It was obvious why the child didn't learn any[thing] on their own. The child was very clingy, and the mom did not like what she [the child] set up and did not let him complete the development. So, the therapist would have to go in and intervene with the mother and model for the mother [regarding] how to play with the child. . . . The hardest thing was getting the mother to do what we
described. I think that is part of what . . . needs to happen, but getting people who need to
do it . . . It really is family therapy; it is really not therapy with a child.”

I ventured further regarding the director’s ideas about the inclusion of the parents in the trauma curriculum. She began speaking before the question was completed: “I would like to be able to do a parent’s group simultaneously with the children's group.” She said she saw this as a method “to explain, as we go, to the families what their child might be doing, what their child might be experiencing, without coming out and saying: ‘OK, your kid said such and such.’ It would be more like saying, ‘This is what you should expect.’ It is very hard for mothers to understand that when their daughter has been the victim of incest [with] the mother’s paramour, . . . the mother is going to get the greatest amount of anger from that girl. So, just teaching parents about basic things to expect from their children may be helpful.”

She identified another benefit of the parent group as providing the parents with “an opportunity to talk about how their child's trauma has traumatized them, as well as a chance to discuss their own traumas that are going to get in the way of them being able to help the child get through their trauma. . . . We have a lot of mothers, once we know that the child has been abused, then the mother comes in and says ‘such and such happened to me when I was this age.’ It is amazing how many of the mothers of the kids have, not one but, multiple traumas in their own growing up, and they have never processed any of their traumas. They have a kid that who has gone through a trauma, and they are bouncing symptoms back and forth off of each other, and it is hard for them to get into a working relationship because they are just triggering trauma reactions in each other.”
She continued to mention other changes, including the physical environment, she wanted to make at New Directions. “The biggest thing we need at this point and time is more space so that we could have some special spaces for therapy to happen. Therapy could slow down here, no doubt, because it is so very difficult to find really private places with them [the children] to do an individual session.” She stated that, just being in a smaller, more “off the beaten path” room, one did not have to worry about being overheard or overhearing someone else. She also discussed the traffic in the halls as distracting during therapy sessions.

Continuing with the discussion of environment, the medical director said: “I noticed a total difference in the adolescent groups from one year to the next as soon as we started meeting in the library. While there were different kids with much more focus and they were much more involved, there was a noticeable decrease in the level of resistance.” She attributed this to the quieter setting in which the trauma sessions took place.

I guided the interview in another direction, asking about the medical director’s views on the differences between the children’s and adolescents’ groups. Regarding the adolescents, she presented that “it is kind of a two-way sword . . . because they are older, I think it is harder for them to buy into why they need the process of ‘I'm OK. I am going to be OK.’ But, then I think sometimes they suffer more because of it, and so, maybe, they are more likely to talk. . . . I think they are more rebellious and are less likely to succumb to parental pressures.”
Concerning the younger children the medical director stated that there were “so many factors that impinge upon them . . . the messages they get from their families about ‘do and don't talk’ and ‘what you do and don't talk about’ . . . You always have to be worried about that, and it is interesting, because in doing the trauma track, we have actually lost kids from treatment, particularly the little ones. We [the staff] suspect we have gotten too close to secrets that the family doesn't want out, and so they will pull the child from the program rather than have them continue. It is not just the trauma track. It is just the fact that the child gets more comfortable with us. However, this has been more noticeable since we have had the trauma track. We have been so focused on finding and processing the trauma. New Directions has no interest in penalizing a parent if they were a source of a trauma. If anything, we want to get them . . . help. . . . One of the things that bind us as mandated reporters is if the child divulges, we have to report.” She commented that “reporting can destroy the therapeutic relationship as our goal is to help the family. . . . It penalizes them, and, by having Children and Youth come in to investigate and putting the parent in jail, serves no purpose whatsoever. If anything, it is another trauma to the child.”

Next, I asked about parental support for New Directions. The medical director explained that many of the children who attend the program have been in several other treatment modalities such as outpatient, in-home services, family-based or wraparound services, inpatient, or an RTF (Residential Treatment Facility). She indicated that, initially, parents may be suspicious because they do not know “who we are,” and they do not understand the relationship with CYS. However, she said that “for the most part, the
parents are supportive, while, often, not always sophisticated in how to support
treatment. . . . It is just that they may say something because they don't know
better. . . . That is why we request monthly meetings with the [parents and the] therapist
to try to school them [the parents] about how they can support their child in treatment.

We teach the children to open up . . . and talk about problems, and, then, they go home
and they try that with their parent, who may not be in the mood to listen and
problem-solve with them. The parent says, ‘You are always complaining and fussing
about something. Go play with something.’ Well that shuts the kid down.”

The medical director said that the staff must educate parents and redirect them by
providing reasonable suggestions such as “giving the child an appointment” time during
which they can sit together and talk. She said that the child then knows that the parent
will talk with them, and the parent knows that it is important to talk to their child. She
also reported being sensitive to parents who may have had a bad experience. “We have to
be very careful and move more slowly with those parents [in order] to maintain them, so
that the child could stay in treatment.” She concluded by saying their work involved more
than “just treating [the] child.” She went on: “We will call the families. We’ll send
journals back and forth every day so we can know exactly what is going on. The kids tell
us we are nosey and we’re too involved. But that is exactly what we are. We are very
involved.”

To end the interview, I asked about the impact of poverty. The medical director
quickly responded: “Fayette County is a set-up for trauma. We have the highest rate of
substance abuse, we have the lowest rate of people being employed steadily, we have the
dissolution of a nuclear family in the county. I mean, there is nothing to pull us out of that social configuration, where incest becomes much more acceptable, where people have high frustration levels. . . . Children are easy targets to be abused one way or the other.”

_Emerging Themes._ The interview with the medical director of New Directions yielded 23 themes. They included additional interventions, application of interventions, behavior problems, boundaries, client growth, clinical growth, communication, culture, development, diagnosis/symptoms, disclosure, empathy, environment/structure, family systems, lack of training, organization, parental involvement, poverty, process, resistance, sensory, support for trauma groups, and theoretical orientation. These themes are listed in Table 9 and discussed below.

Table 9

_Emerging Themes from Key Informant Interview with the Medical Director at New Directions_

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Additional interventions. In addressing this theme, the medical director said it was important to bring in some different models and theories to the partial hospitalization program. We discussed what Stanley Greenspan (2002) called “floor timing,” where he says that children, for a variety of reasons, have their development disrupted or sidetracked, and they don't complete a developmental circle. The medical director also indicated that she “would like to be able to do a parent’s group simultaneously with the children's group.” She sees this as a method “to explain . . . to the families what their child might be doing [and] . . . experiencing.”

Application of interventions. This theme was qualified by observations she reported. The children who had been through the trauma groups had “generalized” and when they were stressed in places unrelated to their trauma history, they used the “techniques that they [had] been taught.”

Behavior problems. In discussing a client, the medical director commented that, once the client went through the trauma groups, learned some of the skills taught there, and did some processing, the client was able to make remarkable progress. She added that the client had been able to control her anger and her emotional outbursts.

Boundaries. The medical director made it clear that “learning about boundaries” was “essential.” She insisted that the therapists “communicate this message to their clients: ‘I am not your friend, and I am not here to be your friend, I'm your therapist. I am here to be the instrument of you getting better. I may not make you totally better, but I am the stepping stone to your recovery.’”
Client growth. The indication for this theme came from the medical director’s assurance to her staff that “some children return several times and each time they improve in some area.” She also stated that the degree of improvement in some children was “amazing.”

Clinical growth. After the start of the groups, she reported seeing the staff act in a “more spontaneous” fashion, willing to present a child’s symptoms, including dissociation. She said that the trauma groups and training had “allayed their suspicions and their capability of seeing a child having the signs of a trauma. And then trying to get the child . . . to come forth with the information and process it.” She said their skills increased and saw them applying a greater number of skills. Because of the trauma training, the clinical staff now had some “clinical pathways” to follow. She said that the staff knew more and could ask appropriate questions of their clients or engage in a particular kind of play or activity in order to get the client to disclose more information. The staff, she said, knew more about the problems the children had and were better armed with the information needed to know what to do.

Communication. The emergence of this theme was epitomized by various statements. “We teach the children to open up here and talk about problems and then they go home. . . . That is why we request monthly meetings with the therapist to try to school them about how they can support their child in treatment.”

Culture. The medical director stated that Fayette County was a setting in which trauma would be easily found: “We have the highest rate of substance abuse, . . . we have the dissolution of a nuclear family in the county. I mean there is nothing to pull us out of
that social configuration . . . where incest becomes much more acceptable, where people have high frustration levels.” She added that “children are easy targets to be abused one way or the other.”

*Development.* The medical director noted that, when the clients were going through the trauma track, and they got upset and were restrained, they reverted to the behavior they displayed when the trauma originally occurred and where their development had been arrested. She said it was often like the behavior of a two or three-year-old, with temper tantrums, crying, being in control, and thumb sucking. She said “it makes you know that they still do not have all the complete developmental circles.”

*Diagnosis/symptoms.* The medical director commented that the statistics she had seen in Pittsburgh were repeated in Fayette County. She added: “We have children that are actually hospitalized several times, and the physician at the hospital never uncovers the trauma.”

*Disclosure.* The medical director sees the disclosure factor in several ways. The staff is able to manage disclosures resulting in the parents withdrawing their child from the program, due to the child’s statements. “We really want to help the families . . . in doing the groups. We have actually lost kids from treatment, particularly the little ones.” She stated, “We [the staff] suspect we have gotten too close, . . . and so they will pull the child from the program rather than have them continue. It is not just the trauma track. It is just the fact that the child gets more comfortable with us. However, this has been more noticeable since we have had the trauma track. We have been so focused on finding and processing the trauma.”
Empathy. The medical director expressed empathy when she reported the difficulty in finding private places in which to conduct individual therapy sessions. Regarding adolescents, she indicated it was “harder for them to buy into why they need the process of ‘I’m OK. I am going to be OK.’” She added that adolescents “suffer more” because of that.

Environment/structure. The medical director reported: “The biggest thing we need . . . is more space so that we could have some special spaces for therapy to happen.” She indicated a need for rooms in which one could not be overheard, nor overhear. She also commented on the noise from the hallways being a deterrent to therapy sessions.

Family systems. This theme was exemplified by her statement that she and the staff discover that many abused children had mothers who were also abused. She said the mother and child often bounced symptoms back and forth. She said it was difficult to get into a “working relationship because they are just triggering trauma reactions in each other.”

Lack of training. She also knew, by the “nature of academia,” that therapists, regardless of their educational backgrounds, “really don’t have an extensive knowledge of trauma and how trauma presents itself in children ages 5 to 18.” Additionally, she commented that by watching a therapist, she could ascertain that they knew the theory but did not know the practical applications necessary to take action once trauma was identified.
Organization. This theme was identified by comments made by the medical director. She stated that results are more readily seen in a partial hospitalization setting due to the frequency and intensity of the therapy that occurs.

Parental involvement. The medical director commented on the monthly parent meetings, saying “parents have asked about the Pretzel. We [the staff] trained the parents one evening on the Pretzel and how to use it. We have gotten feedback from a couple of those parents on how they are now using the Pretzel techniques because it helps [their children] feel better and more relaxed. The parents know how it works and have a better understanding.” She said that the parents encouraged their children to use the Pretzel when they saw them getting upset or anxious. She also said that “teaching parents about basic things to expect from their children, may be helpful” and added “for the most part, the parents are supportive. While often not always sophisticated in how to support treatment,” she said they may say something simply because they don’t know any better. She said that is one of the reasons for the monthly meetings— to school the parents on how they could support their children during treatment.

Poverty. She reported, “We have the highest rate of substance abuse, we have the lowest rate of people being employed steadily, we have the dissolution of a nuclear family in the county. I mean there is nothing to pull us out of that social configuration.”

Process. She also addressed the restraints used with clients with behavior problems and how the groups play a part in this issue: “We track restraints on daily, monthly, and yearly bases. After the completion of the first section of trauma groups, we had a major spike in our restraints from a few of the kids.” On reviewing the situation,
she and her staff contributed that situation to the process in which the clients were engaging, opening up many issues they could not deal with during that first session.

**Resistance.** The medical director addressed the theme of resistance when she said, “I noticed a total difference in the adolescent groups from one year to the next as soon as we started meeting in the library. While there were different kids with much more focus and they were much more involved. There was a noticeable decrease in the level of resistance.”

**Sensory.** The medical director remarked on the sensory aspect of the trauma curriculum. She said: “So, something different than what we have been using has to come along.”

**Support for trauma groups.** She offered that her “idea of creating a trauma curriculum” at New Directions was an “old concern” of hers. However, the trauma groups and training sessions allayed any fears she and her staff had regarding their ability to see the signs of trauma in a child.

**Theoretical orientation.** The medical director discussed the sensory motor and movement emphasis of the trauma curriculum. She said: “The whole field of trauma has to be creative.” She commented that the best results were not forthcoming based on the information known in the field for years and stated that other innovative interventions were thus required.
Summary

The Participants

There were six focus group meetings, one of which (the focus group with the teachers, teacher aides, and student teacher) had two sessions, and three key informant interviews, one of which (the interview with the two representatives from the county) included two persons. A total of 45 people was interviewed in a total of 10 sessions. Of the 45 participants, 36 were female and 9 were male.

I audio taped all sessions and reviewed them and then transcribed all of the tapes. Even though the sessions were taped, I took notes following the meetings so as to remember key points or nonverbal behavior or reactions. While transcribing the tapes, I would recall a nuance or a reaction and make note of it in the margins. I reread the transcripts many times and then began to identify the themes from each group.

Themes

A total of 34 themes was identified from the focus group and key informant interviews. Table 10 summarizes these themes for the reader. To be included, a theme emerged from at least one of the focus groups or key informant interviews. An “X” in the table indicates that the theme emerged in that session. When the theme was not found in the session, the table cell is left empty.

Collapsing of Themes

As I examined the themes that emerged from the various focus group and key informant interviews, the expert practitioners stood out for several reasons. First, their perspective was significantly different from those of the other individuals interviewed.
Second, the expert panel had no connection with Fayette County or New Directions and did not know any of the clients or staff. Third, as a group, they were committed to understanding and providing treatment to those who experience traumatic stress. Fourth, their perspectives encompassed trauma theory. Fifth, they evaluated the structure and content of the curriculum. They did not give their perspectives on the effects of the trauma curriculum on the program at New Directions, nor did they have new perspectives of trauma as a result of the implementation of the curriculum. As it turned out, however, their perspectives were important in the manner in which I categorized the various themes that emerged.

Table 10

Summary of Emerging Themes

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<tr>
<th>Theme</th>
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FT = Teacher/Teacher Aide/Student Teacher Focus Group  
FA = Adolescents’ Therapists Focus Group  
FC = Children’s Therapists Focus Group  
FP = Parent/Caregiver Focus Groups  
FE = PPSSTD Expert Practitioners Focus Group  
IC = Interview with HC and MHMR  
IN = Interview with Psychiatric Nurse  
IM = Interview with Medical Director
As I reviewed the summary table of all emerging themes (Table 10), I realized that the contents of the table did not speak clearly to this study. In the process of reviewing the data, information from the expert panel stood out as the themes I identified from their focus group interview seemed to describe or center around cultural issues, a fact that I had overlooked and not considered. Further review and discussion of the information with my dissertation committee and colleagues led to the agreement that the themes could be further collapsed into categories. Three categories—organization culture, clinical culture, and psycho-social culture—filtered through my evaluation.

With these three categories in mind, the 34 emerging themes were assessed and assigned to one of the three culture categories. Table 11 shows this categorization.

The reader will note that culture and organization, two of the emerging themes originally identified in this chapter, are not listed in Table 11. Because Table 11 is a culturally-based table, those emerging “culture” themes will now be included with one of four other themes—environment/structure, family systems, parental involvement, or poverty.

The reader will also note that seven of the emerging themes—boundaries, communication, process, repeating the trauma groups, resistance, safety, and support for the trauma groups—are listed under more than one cultural category. Communication and safety appeared in all three of the cultures. In this study, safety emerged as a theme in the context of emotional safety across all cultures.
Table 11

*Emerging Themes Listed by Category*

<table>
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<tr>
<th>Organization Culture</th>
<th>Clinical Culture</th>
<th>Psycho-social Culture</th>
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<td>Vicarious Traumatization</td>
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</table>
The Cultures

While a discourse on cultural trauma is beyond the scope of this study, some discussion is indicated in connection to the themes that have emerged and placed in a cultural context. The culture of trauma is a context to be considered in relationship to the emerging themes collected from the data of this study. A culture consists of the beliefs, values, and traditions that an individual or group of people embrace and can also include an individual’s world view of their experiences (Patton, 2002; Lewis & Ippen, 2004). Cultures have social and religious rituals to help individuals and groups work through their loss, death, traumas, and disasters. Cultures communicate the value of relationships, support interaction among its members, and guide their members in responding to traumatic situations.

Sue et al. (1998) stated that “all organizations have an organizational culture” (p. 13) which, according to Schein (1990), consists of basic assumptions that are developed, discovered, or invented by a group as it learns to cope with problems of “external adaptation and internal integration” (p. 111). Arranging the emerging themes into one or more of the three identified cultures is in line with the work of these authors.

The New Directions culture supported the treatment of trauma, because the organization, in general, maintained that traumas endured by children affected their learning, their relationships, and their overall functioning. Because the structure of a partial hospitalization program can be flexible in meeting the individual needs of the clients it services, it was possible to implement groups with a trauma focus as part of the overall program. In the focus groups and individual interviews, the therapists, teachers,
the psychiatric nurse, and the medical director were able to communicate their
impressions of the world views of their young clients.

Organization Culture

The organizational culture is basic to this study. New Directions provided service
to a diverse population of children and adolescents who, due to their serious mental
health and behavior problems, were unable to function successfully in at least one domain
of their lives–school, home, or community. Based on her career as a child psychiatrist, her
previous work experiences, and her knowledge of and insights into the lives of the
children and adolescents serviced by the New Directions staff, the medical director
guided and gained the support of the staff regarding the implementation of the trauma
curriculum, a program she was determined to implement. As an organization, the New
Directions staff knew that many of the children and adolescents enrolled in the program
had suffered or been exposed to traumatic events, many on a chronic basis. This
information was gained by direct information provided by the children, adolescents, or
their caregivers or through assessments and observations of the clients. The willingness of
the professional staff to implement the trauma program after recognizing the needs of the
children and adolescents in their care brought credibility to the facility and reinforced
their recognition and understanding of the culture they were serving. Because of the
statements made in the focus groups and key informant interviews by the staff of New
Directions concerning the implementation of the trauma groups, it is evident that their
values complemented the New Directions culture. The organization’s trauma focus
initiative was reinforced by the medical director when she provided training, both
internally and externally, for the staff. This training complemented the ongoing support that occurred in the case consultation meetings held twice each month for the entire staff.

Evidence of organization culture is found in the data collected from the focus group and key informant interviews conducted during this study. Nine of the emerging themes related to the organizational culture (see Table 11). Two of the nine themes in this category—environment/structure and support for the trauma groups—were endorsed by all of the participants in the study.

*Environment/structure*

In addition to the physical aspects of the New Directions facility, the environment/structure aspect of the program also refers to the way in which classrooms, groups, and recreational opportunities for the children and adolescents were arranged. The medical director and the children’s therapists spoke of their desire to change the physical environment to one more conducive to a “calm, relaxed atmosphere.” They stated that yelling and other noise from different parts of the building, including the hallway, distracted the participants of the trauma group sessions. They also spoke of needing more space. The teachers spoke of structuring their classrooms in order to meet the needs of their students and stated they were willing to reduce the size of an assignment for students having a difficult time either emotionally or academically. The nurse offered that she received support from the organization when she asked to begin the bell choir. And, one of the parents said that New Directions had done “a good job” with their son who “needed help.”
Support for Trauma Groups

Support for the trauma groups was also endorsed across all groups and additionally fits with psycho-social culture. The medical director announced, “Everybody has a higher IQ here on trauma. . . . We don’t miss it.”

The parents indicated that the groups “belong here.” The children’s therapists said that behavior would not have “calmed down” had the trauma groups not been incorporated into the program. The adolescents’ therapists simply stated, “The groups are a fit.” The children’s therapists stated the groups are here because the children needed them and that they have “helped.” This group also said “there is no getting around them.” The nurse declared that the entire program, including the staff and the clients, benefitted from the inclusion of the trauma curriculum.

Lack of Training

Lack of training, another organization culture theme, was identified in seven different interview sessions. Only the teachers had nothing to say in their focus group regarding this issue. While the comments offered by each of the study’s constituents were different, they related to the lack of training found in those most closely associated with the children and adolescents in the program. One of the county representatives said: “Therapists do not have fundamental knowledge in trauma therapy.” One of the parents stated that the “counselors don’t know what’s behind the behavior.” A parent expressed his frustration this way: “We’ve talked to some dumb people [therapists in general] who don’t get it.” A therapist who worked with the children in the program stated “I did not learn what caused the behavior or how to help a child feel safe” in referring to her
academic preparation. In the PPSSTD focus group, one expert practitioner voiced, “It is amazing how many therapists [in general] lack understanding about trauma.” A therapist for the adolescents in the program reported never having trauma mentioned as a clinical issue to be assessed in his pre-service training program.

Communication

Two other organization culture themes—communication and additional interventions—were cited by six different constituents. Some of the statements regarding communication were more centered in the psycho-social context. Communication, as discussed by the informants, relates to the way information was disseminated internally to the staff and externally to other parties—schools, county offices, community resources, and parents—affiliated with the program. Communication also refers to the manner in which the New Directions organization received information from other sources. This included journal notes from parents to the therapists, telephone calls to the facility, and meetings with the clients’ families. The teachers specifically requested improved internal communications stated that they were “out of the loop” when it came to the dissemination of information at New Directions. They wanted information regarding which students would be attending the trauma groups. They also wanted to be better informed with clinical information that might affect the students when they re-entered their classrooms, particularly after participating in a trauma group session. The parents indicated that they were informed about the trauma groups, but they requested ongoing information regarding the effects of trauma on their children. The study group suggested that staff not
directly involved with the children and adolescents at the partial hospitalization program needed to be educated about the needs of the children.

*Additional Interventions*

Regarding the addition of interventions to the trauma curriculum, the expert study group suggested a game used by several of the adolescent therapists in the focus group. An adaptation of Hang Man, the game used trauma-related words taught to the participants. Positive results were reported regarding the use of the game in other settings. One of the adolescents’ therapists at New Directions suggested applying an interactive intervention using childhood toys to stimulate discussions of family issues. The medical director wanted to apply different models including Floor Timing from the work of Stanley Greenspan. She also wanted to increase parent involvement. The county representatives supported the implementation of a family/parent group to complement the trauma groups in which the adolescents and children took part. The parents also voiced a desire to have a parent group. The parents also asked for an opportunity to meet with their children in a group setting.

*Safety*

Safety in the organization culture refers to a physically and emotionally safe environment for all who entered the building. It was discussed in three of the focus groups and in one key informant interview. Understandably, this concept was endorsed by the medical director who said that safety of the staff and the clients was a priority at New Directions. The issue of safety was discussed by the teachers who asked for suggestions
of ways to keep their classrooms safe. The adolescents’ therapists spoke of keeping the environment safe for their clients.

**Boundaries**

This theme was included as a relevant issue of discussion by two focus groups and one key informant interview. Boundaries involve the setting of clear limits within a relationship or organization. The medical director stated that establishing boundaries is an essential component of an effectively operated therapeutic community. She said she had trained the therapists to communicate that message to the children, adding that the therapists are “stepping stones to recovery” for the children and adolescents. The teachers said they expressed clear expectations in their classrooms regarding behavior boundaries; the students were to remain in their seats, no yelling or throwing of objects was permitted, and students were not to touch other students in any manner.

**Parental Involvement**

Parental involvement, another theme of the organization culture category, was addressed by the parents who wanted additional information regarding the content of the trauma groups in order to “better support their children.” The parents also suggested that an information meeting for the parents be held before the trauma groups began. It was also addressed in two of the key informant interviews. The county representatives spoke of parental involvement when they offered that the “transportation problem could hinder parental participation.” They also said that research reports indicated that greater parental involvement led to increases in the success rates of their children. The medical director saw the parents as supportive and felt it was important to teach parents “the basics.”
Exclusion

Exclusion was a theme heavily endorsed in one focus group—that of the teachers. They reported feeling “out of the loop” when it came to the trauma groups, and they said they were working “in a vacuum.” They expressed discontent in that they did not know what was going on in the trauma groups and said the communication from the therapists and me following group sessions was limited. They said they often were in the dark regarding the behavior of the students.

Clinical Culture

In this study, clinical culture refers to the theoretical approach, beliefs and values of the therapists and the manner in which the therapists related and worked with their clients concerning trauma issues. In trauma theory, it is important to gage the pace of therapy so that the client can tolerate and process what is occurring in the present as they address the past. In treating trauma, therapists need to be familiar with the various cultures of their clients. For instance, in this study which occurred in Fayette County, a rural area in southwestern Pennsylvania, consideration needed to be given to the high level of poverty. Research suggests higher levels of domestic violence and community violence in impoverished areas (Graham-Berman & Halabu, 2004). The clinical culture is relevant in this study as are the 20 themes related to this cultural category. Behavior problems and diagnosis/symptoms were identified by all focus groups and key informants, and four themes—client growth, clinical growth, process, and theoretical orientation—were endorsed by seven of the interviewed constituents.
Behavior Problems

Two of the themes in this cultural category—behavior problems and diagnosis/symptoms—were included in the discussions of all focus group and key informant interviews. The nurse offered that behavior problems were the basis of many of the referrals to New Directions and, with that in mind, she was amazed at the way the children adapted to the bell choir she initiated. The teachers described noticeable classroom behaviors including restlessness, inattentiveness, emotional outbursts, and tearfulness. The children’s therapists spoke of physical and verbal aggression on the part of their young clients. A grandparent related how her grandson would “flip out” at the most unexpected times. The study group offered that traumatized children often exhibit “disorganized and clingy” behavior.

Diagnosis/symptoms

At times, behavior problems are indicators of symptoms in a particular diagnostic category. The expert practitioners addressed trauma diagnoses such as PTSD, Attachment Disorders, and Dissociative episodes that could be present in the population for whom the curriculum was designed. The county representatives spoke of symptoms known to be “red flags” for traumatic stress—enuresis, encopresis, nightmares, and sexual misconduct. They also voiced concern that trauma effects are often mistakenly described as Conduct Disorder or Oppositional Defiant Disorder. One parent voiced her confusion: “Sometimes I think it is the ADHD and sometimes the trauma. I have a hard time knowing.” Another parent provided examples of behavior exhibited by her child. Not realizing she was describing forms of anxiety, the parent said the child became overwhelmed and fearful in
new situations and said that separating from her was traumatic for the child. The parents also remarked that they were often not heard when identifying concerns regarding their child or when making suggestions regarding interventions that helped their child. The teachers said they observed several symptoms including attention problems, low self-esteem, and fatigue. One of the children’s therapists described in graphic detail a client discussing a trauma with no show of affect or recognition that something was wrong.

*Sensory*

The theoretical approach emphasized in the trauma groups was of a sensory nature, with cognitive and emotional aspects to a lesser degree. Memories are first processed through the senses. Therefore, when an unprocessed aspect of a memory is recalled, it is done so on a sensory level. While discussing a memory is an option, in many cases the “memory” is realized in a “felt sense.” Additionally, talking about the memory does not change the sensory experience. In working with the sensory model, therapists taught clients how sensations in their bodies provided signals that they should apply one or more of the ameliorating techniques.

Discussion of the sensory aspect of the trauma curriculum occurred in three of the focus groups and in all three key informant interviews. The therapists reported that it was not unusual to hear one client prompt another with “maybe a timeout would help” or “the Pretzel might be an idea.” These were nonverbal activities a child could decide to do or not do. (Timeouts were not only permitted but also encouraged within at the partial program.) The children’s therapists saw the movement interventions used in the trauma
curriculum as safe ways for the children to express their emotions. (They mentioned Target Practice.) The expert practitioners in the study group clearly and immediately recognized the high level of movement in the curriculum and questioned the ability of the participants to ground and focus themselves in order to continue with the remainder of the trauma group session. The nurse identified the sensory interventions as positive experiences that helped her in organizing and implementing the bell choir, because it utilized sensory processing that was visual, auditory, and tactile in nature. The county representatives reflected on the sensory approach and stated it could be helpful in treating individuals with “minimal cognitive abilities.”

Theoretical Orientation

Related to the sensory theme is the theoretical orientation theme. It was addressed by seven of the constituents in this study. The adolescents’ therapists were quite vocal about this issue. One therapist noted that the “cognitive-behavioral approach” might not be the “best way to capture trauma.” Another therapist commented that the treatment approach was not “therapist directed.” The county representatives said they supported the “training the trainer” model, while acknowledging that there are varied opinions regarding the treatment of trauma. The psychiatric nurse talked about the neurobiological component of the curriculum, which encourages full-brain activities. In traumatized individuals, the portions of the brain that perform information processing are shut down or compromised; however, sensory motor activities promote internal changes in the brain and provide ways in which neuro-pathways can develop. The parents were also vocal regarding this issue. Several expressed frustration with the use of “stickers and charts.”
They said they wanted therapists to work with their children so that they would “open up.” One father stated, “If a child is upset, he won’t learn. Head don’t work that way!”

Clinical Growth

Clinical growth was identified as a theme in seven of the eight interview areas. The medical director reported an overall increase in the therapists’ self-confidence and awareness of trauma effects. The children’s therapists reported an improved understanding of why children act in particular ways. The adolescents’ therapists concurred, saying that “it takes a lot to grasp the dynamics of the trauma groups.” Another of the adolescents’ therapists disclosed, “I thought it [trauma] was voodoo. I no longer believe that. It works.” The nurse said she did not realize the “profound effect and long-term consequences” early trauma could have on a child.

Client Growth

Client growth was identified as a theme by six constituent groups in the study. The medical director recognized client growth when she saw children implement Pretzel in situations that were not necessarily trauma related. The teachers objectively reported seeing improvements “in some but not all” of their students as a result of the trauma group sessions. The children’s therapists noticed that their clients improved in their abilities to work together and show respect for one another. The parents endorsed this theme when one remarked, “My son has come a long way.” Another parent shared, “The Pretzel calmed him better.”
Clinical Experience

Clinical experience was indicated as a theme by the expert practitioners, the county representatives, and the medical director. The county representatives said that their clinical experience had taught them the relevance of asking what had become a driving question in their work: “Who is the parent?” They explained that determining who is the parent is critical in their work and prompts what they say to the person with whom they are speaking. Determining who is the parent contributes to the perception and treatment of the child and indicates the services that will be provided. The parent, they explained, could be the biological parent, a foster parent, a relative, or CYS (Children and Youth Services). The study group discussed clinical experience when they emphasized that my own clinical experience influenced the curriculum.

Closure

Closure was indicated by the group of expert practitioners. Several therapists reported that during the closure group for the adolescents they have a party. They suggested this be considered for the children and adolescents at the partial hospitalization program. I laughed and related that indeed there were closure parties at the end of each section of the groups. This theme did not emerge in any of the other groups or key informant interviews.

Empathy

Empathy was validated in six of the focus group and key informant interviews. One of the children’s therapists shared, “I do not think I could tell one of the most terrible things that ever happened and then go to class and act as if nothing had happened.”
Another therapist reported wanting to tell the young clients: “Everything will be OK” but acknowledged that must not be said. A parent said: “How can you leave that stuff on the table and go back home?” The teachers said they did not want to respond to their students in a way that would aggravate them. The adolescents’ therapists shared that they believed that the teenagers struggle, but that they seem to work through it.

Process

Another clinical culture theme, process, was supported by seven of the interviewed entities. The medical director said that during the initial trauma groups, the number of restraints increased initially and then decreased. She reported that the students then “began to process and opened up in ways they had not [done so] before.” The teachers’ process was more intuitive in nature. They addressed my questions by providing detailed descriptions in a narrative form. In other words, they told stories. One of the adolescents’ therapists provided an example in which the client’s process affected the clinician’s thinking. Another therapist reported that, in general, the beginning exercises served as a “joining process.” After the exercises were performed at the beginning of the trauma groups, the group process “took off.”

Resistance

Resistance, a theme confirmed by three focus groups and three key informant interviews, could be considered a clinical process as well in the psycho-social culture. The adolescents’ therapists came face-to-face with resistance in the first section of the trauma groups. The resistance was intense, and the therapists came to realize that the teens felt they were thrown into a situation about which they were uncertain. Due to the
resistance, the group continued for three weeks longer than had been planned. The medical director reported a reduction in the level of resistance when the groups moved from an open classroom to the smaller library/conference room. Further resistant statements heard by the therapists included: “This is dumb” and “I don’t have issues.” Several of the expert practitioners who worked with adolescents indicated reticence in their clients “until they have a sense of acceptance by the group.” When group contracts were provided, one member refused to sign. The same individual requested to sign the contract after speaking in the group.

Safety

Clinical safety was identified in three focus groups and in one key informant interview, and across all three cultures. The adolescents’ therapists reported that emotional safety is instilled in the groups and that the adolescents are informed they do not have to discuss traumas. A parent urged, “Kids need help to get the stuff inside, out. They need to know it’s OK to talk and be safe at the same time.”

Boundaries

The theme of clinical boundaries was detected in two focus groups and in one key informant interview. Statements about boundaries can also be found under organizational culture. Clinical boundaries often complement safety. The medical director encouraged the therapeutic staff to be clear with the children and adolescents regarding expectations within the program and to clearly explain the staff’s roles in engaging with the youngsters. The children’s therapists stated that they lowered the wall between themselves and their clients by providing limited information in order to build rapport
with their charges. However, the “personal” information was benign in nature and included, for example, whether or not they had a pet and giving the name of their favorite color.

*Counter-transference*

Counter-transference is expected in the clinical process and involves the stimulation of feelings within the therapist. Some of the feelings are accurate; others are not. Sometimes the feelings are positive in nature; others are negative. Therefore, some accurate feelings are positive and some are negative. Alternately, some inaccurate feelings are positive, while others are negative.

This theme was validated in four of the focus group interviews. A teacher claimed that a student acted out to intentionally upset her. While this was the teacher’s reaction, it is not known if the feeling was accurate or not. A similar example was expressed in the focus group with the adolescents’ therapists. One of the participants claimed that one of the adolescents “used resistance as an excuse to act out.” Concerning a child client, one of the children’s therapists pronounced, “She drew a picture and could not connect it with anything, which is why she did not share.”

*Vicarious Trauma*

Vicarious trauma involves a change within someone in a helping role, such as a clinician, as result of working with a trauma victim and the victim’s traumatic stress (Jankoski, 2002). By the very nature of their jobs, the staff is at risk for vicarious trauma, although not everyone is aware of it. Self-care, which includes pursuing outside interests, exercising, being with family and friends, eating nutritionally, and maintaining a balance
between one’s work and personal life is necessary to manage the overpowering reactions one experiences from constantly working in the field of trauma.

Vicarious trauma was a theme in one focus group and two key informant interviews. The county representatives voiced concerns for the staff due to the intensity of the environment and trauma issues they encountered on a daily basis. They indicated that the staff had little down time, which makes them susceptible to vicarious traumatization. The nurse stated that some days were overwhelming for her and that she did not always know what to do with her feelings. She developed an understanding of vicarious trauma “everybody has a higher IQ here on trauma. . . . We don’t miss it.”

Disclosures

Disclosures were mentioned in four focus groups and two key informant interviews. The study group assumed that disclosures would occur and were concerned as how this would be managed after the child leaves the group. The medical director explained that as the children become more familiar they tend to disclose and this has increased since the groups began. She states sometimes this results in parents withdrawing their children from the program. The nurse talked about the week that there were three disclosures and that the children were able to talk “openly” about the traumas they endured.

The children’s therapists addressed the contagion factor. When one child or adolescent discloses, others follow. The adolescents’ therapists observed teens who refused to talk at the beginning of the trauma group sessions. However, they started to disclose information about their experiences. An aunt of two nephews related that after
one year of living with her, the boys disclosed that they did not want to return to the chaotic environment where they had lived with their birth parents.

Repeating the Trauma Groups

Repeating the trauma groups was identified in two of the focus groups. The adolescent therapists address this from a psycho-social perspective and it is noted there. One of the expert practitioners questioned the benefit of having the adolescents repeat the trauma group experience. Two therapists who had facilitated adolescent trauma groups responded that, in fact, it was their experience that repeating the sessions was typical and usual. They indicated that it often takes two rotations before the adolescents will establish trust with the therapists.

Future Research

Future research was discussed as a theme in the interview with the expert practitioners. They suggested a quantitative study with a control group with adolescents. Additionally, they believed that repeating the curriculum in the schools would be an option.

Intuitiveness

Intuitiveness emerged as a theme in the study group. An experienced clinician simply stated, “You might have to trust the intuitiveness of the therapist in the room at the time with a particular group.” She further commented about the trauma curriculum and indicated that “it worked, and it could have been very well intuitive, that you knew that is where you needed to start and this is where you needed to end. But, in reflection, you can say this is why.”
Communication

Communication was identified in three focus groups and three key informant interviews across three cultures. The teachers said they were open to clinical direction from the therapists in order to be helpful in responding to their students who were struggling.

Psycho-social Culture

Psycho-social culture includes the values, beliefs, and world view of the individual as well as those significant people with whom the individual relates and interacts including one’s family, extended family, neighborhood, and community. This reflects the ecological developmental theory of Bronfenbrenner (1979) who emphasized how families, communities, and peers have a bearing on the development of a child. Bronfenbrenner also stated that events in the home, school, and community affect the child. Thirteen emerging themes supported the psycho-social culture category.

Application of Interventions

The application of interventions refers to the utilization of the interventions taught in the trauma groups by the children and adolescents in other areas of New Directions, in their homes, or in the community. Seven of the participating entities, five focus groups and two key informant interviews, indicated that this occurred on some level. One teacher reported observing a student apply an exercise in the classroom. The children’s therapists and the nurse reported witnessing clients using the Pretzel and Butterfly Hugs in the classrooms, hallways, and other group sessions. The nurse used three Brain Gym® exercises in the bell choir as part of the warm-up to playing the bells. I also witnessed
children using the exercises in the hallway. The adolescents’ therapists reported seeing adolescents demonstrating the Pretzel to peers who had not experienced the trauma groups. These same therapists reported hearing adolescents appropriately use language associated with trauma in their interactions with peers. Members of the study group expressed interest in applying some of the interventions in other programs and with adult clients with whom they were working. Parents described their children using the exercises at home and reported that doing so “calms them.” One parent laughingly reported that she watched her child performing one of the exercises in church. Not knowing what the child was doing, she reprimanded him.

Process

Process, which emerged as a theme in five focus groups and two key informant interviews, also was described under clinical culture. Here, however, process speaks about those characteristics valued by an individual either involved in the environment or valued by someone external to the process.

The parents asked if their children needed to request to be part of the trauma groups. The PPSSTD group addressed the concept of leadership, which did evolve as the children and adolescents took turns leading the three exercises. Also, when the children worked on the safe community project, they identified a leader in each of their subgroups. The study group also stated that repeating of the trauma groups was usual and contributed to client growth. This was exemplified by the process that took place in one of the adolescent trauma groups. When the group began, there was a level of resistance that transformed into several adolescents requesting to repeat the group.
Resistence

Resistence was identified as a theme in three focus groups and in all three key informant interviews. In the psycho-social culture, resistence could be found in remarks made by the nurse who stated that when the bell choir began and before the adolescent males understood what it was about, they thought “it was dumb.” In the classrooms, the teachers said that negativity was clearly heard with statements such as “I can’t do it.”

Safety

Safety was addressed in four of the interviewed constituencies. Two of the perspectives were psycho-social related. It was broached by the parents when one parent spoke of the family being in a house fire that changed the family’s sense of safety. Another parent reported that her child had admitted being abused and asked her if he would be “OK.”

Cohesion

Emerging as a theme in three of the focus groups, cohesion is the ability of a group to work together as a unit. Initially, particularly in the children’s trauma group, cohesion was reported to be in place. However, that changed when the structure of the groups changed. The children’s therapists reported that something was different; it became apparent to them and to me that the children were not working together as they had done earlier in the group process. As a team, we agreed to employ some team building activities. We began with a mural with the word “Teamwork” on it. Then, we had each child write or draw a picture of what the word meant to her or him. Additionally, following the Brain Gym® exercises, a New Directions “huddle” was
activated in the children’s trauma group. In this huddle, the group of children and therapists stood in a circle. The group members stacked their hands inside the circle, counted to three, and yelled “Yeah, New Directions!” This simple exercise helped in strengthening the cohesion in the children’s trauma group. The children’s therapists indicated that Moonball also was helpful in this process. Both the adolescents’ and children’s therapists agreed that doing the exercises at the beginning of the trauma groups provided structure for the groups and built cohesion within the groups. The study group discussed adventure-based programing as a quick positive approach to team building.

**Communication**

Communication emerged as a theme in three focus groups and in three key informant interviews, across all three cultures. Within the psycho-social culture, communication was viewed as essential by the teachers. They felt that the insights they made about what seemed to help a child were discounted or not heard by the therapists. The county representatives spoke of needing to communicate clearly with family members so that appropriate services and authorization for said services could occur.

**Empathy**

Empathy in this culture emerged as a theme in four focus groups and two key informant interviews and comments regarding empathy can be found under clinical culture. The teachers, who were clearly concerned about the children, recognized that their students often were yelled at by various people in their lives. The teachers indicated they did not want to “further degrade or humiliate their students.” The nurse expressed concern for those children and adolescents living in poverty conditions.
Support for Trauma Groups

Support for the continuation of the trauma groups was endorsed by all participation, and also fits in the area of organizational culture. The children’s therapists stated that the trauma groups helped the children and, without the groups, the behavior of many of the children would not have calmed. The medical director commented that, after one year, any suspicions she had concerning the staff’s ability to recognize signs of trauma in the children and adolescents were allayed. The teachers reported noticing some improvements in their classrooms and attributed them to the trauma groups. The expert practitioners stated “there is good stuff here.” Another member of that group announced, “I want to apply some of this with my adult Dissociative clients.” Another remarked, “I would like to try some of these interventions with our program, I think that they would work.”

Transitional Objects

Transitional objects emerged as a theme in the focus groups held with the teachers and the expert practitioners. The therapists in the study group who treated adolescents reported that pens were great transitional objects and that they provided these at their closure parties. The teachers at New Directions noted that one of their students would do “anything” for a pen and that another student would do “anything” for a sticker. As an active participant in the trauma groups, I experienced children who asked to take a figurine, car, or truck home with them when their projects were completed.
Development emerged as a theme in all focus group and key informant interviews. The teachers put it this way: “Many of the students do not function or perform at their chronological age level.” The children’s therapists noted that they often observed parallel play rather than interactive play. They also noted that the children were not aware that their life experiences had been traumatic. This was supported by their reports that there was no change in affect as the children disclosed one trauma after another. Lastly, their statement connected with statements made by members of the study group when they said that the children do not know what normalcy is. The study group addressed developmental differences and said that children, in general, are more comfortable with discussing fears rather than anger; however, adolescents are more open about anger issues and would not readily speak about their fears, due to concerns about what their peers would think of them. The adolescents’ therapists said that the teens reported not having a childhood because they had few memories and little recall of “toys, games, or activities.” A therapist described one of the adolescents who sat and played with a figurine for an extended time while doing the safe environment project.

Family Systems

Two important themes that emerged in this category were family systems and poverty. The family systems theme includes the background and family dynamics that were described in this research. This theme emerged in three focus groups and three key informant interviews. The medical director offered this insight: “Many abused children had mothers who were also abused.” She went on to say that “the mother and child often
bounced symptoms back and forth.” She said this made it difficult to get into a “working relationship” because the mother and child triggered trauma reactions in each other. The parents made comments that underscored what the medical director had reported. One parent related that she never realized how growing up with an alcoholic father bothered her until she started dealing with her past in therapy. Other parents voiced similar concerns. A father received a call from his ex-wife while their son was visiting him. He said that she told him: “He is too much. I don’t want him any more.” Another parent disclosed: “Somebody beat him. I don’t know who.”

Another aspect of family systems was brought up by the county representatives who reported that there was an increase in the number of adoptive families who wanted to terminate adoptions. They reported not feeling prepared to manage the long-term consequences resulting from the chronic and traumatic events in the children’s lives. They also reported not being adequately informed prior to the adoption. The two county key informants also stated that young families did not know how to organize their homes and needed suggestions and support in that area. They reported also being “taken back” by the admission of parents who were well aware that their child or children were being abused. They shared that the parents could not comprehend the negative effects of the abuse on their children. This intersects with statements from the children’s therapists who indicated that “chaos” was passed from one generation to another. The study group presented that adolescents living in group homes often are unable to talk about their trauma or how they feel about what happened. Additionally, they stated that there were some home environments where it is not safe to address these issues.
Poverty

Poverty was addressed in three focus groups and in three key informant interviews. This theme is concerned with the lack of income families experience that is often accompanied by a paucity of resources. A parent painted a picture: “We carry water into our trailer. We have no commode, as a tank needs to be under the ground. We are trying to live with this inconvenience.” A teacher simply stated that one of her students had been living in a car. The county representatives stated that the poverty in the county was “overwhelming.” They commented that it was not just an issue of treating the youth, they also said one had to overcome the environmental issues, the lack of work, and the poverty. The medical director commented: “We have the highest rate of substance abuse. We have the lowest rate of people being employed steadily. We have the dissolution of a nuclear family in the county. I mean there is nothing to pull us out of that social configuration.” The nurse said, “Poverty is a cyclical relationship. The prevalence of poverty among the children at New Directions is supported by the number of clients eligible for free lunches. I can . . . probably count on one hand the number of clients [who] pay for their lunch. The majority of them, through papers that their parents fill out and send into the school districts, are eligible for free lunches, and that is all income-based.” She then referred to the situation as a “risk factor.” The nurse empathized: “Without having that social support, without having finances, without having a car to take your child to an appointment, without education . . . some parents with middle school education [with] only so many skills to fall back on, it definitely impacts them.” She continued, “I think that the poverty impacts why these children have
issues." The adolescents’ therapists referenced the impoverished living conditions and stated: “We have the highest level of poverty, right behind Philadelphia, in all the wrong ways.” They commented that it is a risk factor for trauma, which is supported in the research for this study.

Repeating Trauma Groups

The adolescent therapists related to this theme from a psycho-social context. They were impressed with initial level of resistance on the part of the adolescents and that this has changed to the extent that several had requested to repeat the groups.

Summary

The data from this study supports the ideas that multiple factors contribute to the effects of traumatic stress. While, in general, there is positive support for the trauma groups, there is certainly room for further exploration of ways to help manage the affect dysregulation and the aftereffects of chronic, repeated, and unpredictable trauma on the child. There were 34 themes that emerged from the focus groups and key informant interviews; these were collapsed into three culture-based categories–organizational, clinical, and psycho-social–supporting the finding that suggests the need for multi-faceted understandings of the effects of trauma on children and adolescents.

Culture emerged as a unifying concept that helped to place the data into a workable framework. The staff at New Directions is part of the organizational culture. Because they were sensitive to the needs of their clients, they identified the need for and provided support for the trauma curriculum. Two subcultures evolved from that which included the clinical culture and the psycho social culture. The clinical culture involved a
collective learning by the staff in facilitating the trauma groups and by participating in the
twice monthly case consultation meetings for all of the staff. The psycho social culture
focused on the values, beliefs, and relationships the individual has at work, school, home,
and in the community; this evolved from the data that the focus groups and key informant
interview participants provided as they presented their perspectives of their experience
around the trauma groups.
CHAPTER V
CONCLUSIONS, RECOMMENDATIONS, AND SUMMARY

Introduction

Trauma is an encompassing issue that touches the body, torments the mind, and shatters the soul. In our culture, one of the most influential and powerful in the world, violence is common. Children, one of the most vulnerable components of our population, are influenced by the actions of others. We have a government that states “no child left behind,” yet, it can be argued that many children are left behind, particularly children from lower socioeconomic areas, children of color, those with mental health and developmental disabilities, and children from families that are unaware of or not able to access available services.

The children and adolescents at the New Directions facility in Perryopolis, Pennsylvania, not unlike other youth in partial hospitalization programs, are left behind in many ways. Many of these youth have serious mental health issues, and many experienced repeated and chronic traumatic events in their lives, traumatic events that often are overlooked in general in the treatment of our children. Add to that the risk factors associated with living in poverty, and we find children who are not only “left behind,” but children who are often forgotten. As the medical director so aptly put it, “Even the psychiatrists on children’s inpatient units do not recognize or mention the traumatic histories of our children.”

Trauma continues to have profound effects on the developing child, even long after the occurrence of the traumatic event(s). With that in mind, trauma cannot be
viewed in isolation. Rather, it must be examined from multiple perspectives; included in this study, relevant multiple perspectives were those of the teachers, clinicians, parents, nurse, medical director, and case managers who share my concerns about these traumatized children and who also work to ameliorate the children’s problems.

In 2000, I was asked to train the entire staff at New Direction concerning the effects of trauma on children. Following that training, I was asked to serve as a consultant to the facility regarding clinical issues, particularly the effects of trauma on the youth at New Directions. Later, I was asked to write a trauma curriculum for the program. While I welcomed the opportunity to conduct training at New Directions in 2000, it was the furthest thought from my mind that I would co-create a curriculum and have it implemented at New Directions. It was a great challenge to put forward the variety of relevant theories I had come to understand, to design applicable training, and to implement sensory motor interventions into action. The effects of the trauma curriculum were a key area of focus during the focus groups and one-on-one interviews that occurred during this research.

In order to capture the views of the various adult entities who share intimate relationships with the children at New Directions, particularly those children with histories of trauma, the researcher conducted focus groups and key informant interviews to examine their perspectives in several areas. While the views of these various adult constituents varied, their inclusion or exclusion of certain themes simply reflected a particular focus, role, or involvement in the implementation of the trauma groups. For example, parental involvement was not mentioned in focus groups held with the teachers
and teacher aides, the children’s therapists, and the adolescents’ therapists. Yet, the members of each of these groups communicated, on a regular basis, with families via telephone calls, messages written in journals, or in face-to-face meetings. However the above participants did address family system issues during the focus groups, as did the key informants and parents themselves. While the therapists were in the groups with the children listening to the outpourings of the children, the teachers dealt with the after-group behaviors of their students, and the parents lived with the day-to-day behaviors exhibited by their children.

The purpose of including the perspectives of the participants in the PPSSTD focus group was to have them review the trauma curriculum and offer feedback regarding their impressions of the sensory motor orientation of the curriculum, particularly as a means to help children in managing affect dysregulation and disruptive behavior. While their view was external, my attention became centered on the results of this group. After repeatedly combing through all of the data and thinking about the findings, reviewing them with my committee chair and interested colleges, I was able to associate the themes in a cultural context. This motivated me to review the information again using a cultural frame that provided the impetus for arranging the 34 themes that emerged from the data collected from the interviews, into a format utilizing three cultural categories, organizational, clinical, and psycho-social.

The county representatives, while not involved in the daily operations of the partial, were important key informants by virtue of their job-related functions, referring children to specialized levels of treatment and authorizing the payment of those services.
Their self-admitted recognition of the need for interventions concerning trauma-related issues in children was an unexpected addition to this research.

Evidence and Conclusions

I gathered information in a variety of ways in an effort to arrive at the conclusions reached to this research. Two obvious sources of information were the six focus groups and three key informant interviews. I also reviewed the medical records of the children and adolescents involved in the trauma groups. Some of those records provided a great deal of information concerning the youth’s history of trauma and presenting behavior while other charts provided minimal evidence of trauma involvement. Yet, in the case of the latter, some of the children spoke of the traumas they had experienced. The latter situation could have been due to lack of information from the referral source; lack of disclosure on the part of the child or adolescent; culturally accepted behavior that was not reported by parents, other caregivers, or the children and adolescents; and incorrect diagnoses on students admitted to the program. Additionally, as the researcher, a consultant in the New Directions facility, and participant in nearly all of the 256 trauma group sessions held between January of 2002 and May of 2003, I observed and took note of adolescent and child behavior in the trauma groups and elsewhere in the facility. I also interacted with the staff and took note of their reactions to the youth, the trauma groups, and the organization. I observed the parents and caregivers with their children at two school-sponsored functions. The manner in which the children and parents reacted with each other was noted.
Research Questions

This research was conducted to answer three research questions: (a) How did the trauma curriculum affect the child and adolescent partial hospitalization program at New Directions in Perryopolis, Pennsylvania? (b) What are the perspectives of the multi-disciplinary treatment team—professional staff, parents/caregivers, and county program specialists—and expert practitioners toward the trauma curriculum at the New Directions partial hospitalization program? and (c) Have the perspectives of the multi-disciplinary treatment team—professional staff, parents/caregivers, and county program specialists—changed concerning the concept of trauma and its effects?

Research Question One

How did the trauma curriculum affect the child and adolescent partial hospitalization program at New Directions in Perryopolis, Pennsylvania? In order to answer this question, six focus groups and three key informant interviews were conducted. Additionally, the behaviors of the children and adolescents were observed by the researcher. Bronfenbrenner’s ecological theory of development (Bronfenbrenner, 1979; Thomas, 1996), which asserts that many factors at various levels of a child’s environment contribute to the consequences of traumatic stress on children or serve as a protector, complements this research question. The attitudes a child absorbs at school can affect what occurs at home; conversely, the attitudes he or she learns at home can have an effect on the how the child functions at school. The researcher has incorporated the viewpoints of the staff—teachers, teacher aides, therapists for both children and adolescents, the psychiatric nurse, and the medical director—of the partial hospitalization
program, as well as the parents, all of whom function within the child’s microsystem according to the Bronfenbrenner’s ecological theory. The county program specialist who is responsible for monitoring and auditing the New Directions program and for advocating for the children and adolescents enrolled there, and the representative of the insurance company that oversees the insurance needs of uninsured children in Fayette County and authorizes coverage were interviewed as key informants and are part of a larger system known as the exosystem, which makes decision that effect the child indirectly away from where the child interacts, according to Bronfenbrenner. Additionally, input from the Pittsburgh Professional Society for the Study of Trauma and Dissociation (PPSSTD) was obtained regarding the validity of the trauma curriculum.

The medical director commented on the lack of intensive staff training in the area of trauma. She asked the researcher to assume the additional responsibility of training the clinical staff regarding trauma, its effects, and its amelioration. The medical director’s intent when New Directions began in 1999, was “to train the staff to be aware of the reactions in the children that could be a sign there was trauma history.” The medical director also suspected that the clinicians had little academic training, regardless of their educational backgrounds—counseling, social work, or psychology—and the institutions from which they had graduated. She wanted the therapists to be able to recognize trauma in children aged 5 through 18. Additionally, she commented that recent college graduates were well-schooled in theories but lacked the practical skills necessary to help the clients in the program recognize, disclose, and improve conditions that adversely affected them.
She invited the researcher to join the program at New Directions as a consultant to write and implement the trauma curriculum and train the staff.

*Improved Clinical Growth*

One year after the initiation of the trauma groups and associated staff training sessions, I asked the medical director her sense of the staff’s ability to assess the children and adolescents. The medical director reported that her staff was “more spontaneous” in diagnosing and discussing cases. She said her staff was willing to present a child’s symptoms, including dissociation, which her staff could not readily identify prior to the trauma training sessions. The medical director said that the trauma groups and staff training sessions had “allayed their suspicions” and “increased their capability” to recognize children presenting symptoms indicative of trauma.

She went on to speak about their increased skills, “I think . . . [that through the training], they now have some clinical pathways to follow.” She indicated that the staff is far better informed so that they can ask a particular kind of question or engage in a specific type of play or activity to help the child or adolescent disclose, discuss, or cope with their specific trauma. The psychiatric nurse for the program responded in a similar manner regarding the benefits of the trauma curriculum, “The entire program has definitely benefitted . . . Not only the clients, but the staff as well. . . . I see the staff getting to the core of the problems now.”

The medical director stated that the teaching staff at New Directions functions as a therapeutic staff. While their reporting methods differ from those of the clinical staff, the teaching staff does report on the behaviors of the children and adolescents. She provided
the following scenario: A teacher may come to her and say “You know, it seems like every time I move in a certain way, this child does this, or sometimes they just space out, and I don’t know where they are.” The teachers, she went on, then ask if the child is dissociating “‘like [we] heard about in our training.’” The medical director said that “everybody has a higher IQ here on trauma. . . . We don’t miss it.”

Support for the Trauma Groups

This consensus is shared by the therapists. One therapist estimated that “90% of [the] kids [at New Directions] have some kind of trauma history” and went on to say “I don’t see how we can get around without having [the trauma groups] here. . . . [They are] necessary.” Several therapists said that the trauma groups were introduced into the program because they were needed in order to help the children, and they believe the groups do that. They said of the process, “Something happens, something shifts” and agreed that the trauma groups are the “most intense” groups the children attend.

In examining her thoughts concerning the sensory motor and movement emphasis in the trauma curriculum, the medical director stated that “the whole field of trauma has to be creative.” Citing the trauma interventions that have been used for many years, she indicated they have not been effective and said “something different” must be done. She said she had observed children who had been through the trauma groups and indicated they were seen using the “exercises” they had been taught in order to alleviate stress, even when the stress was unrelated to their trauma histories. One of the children’s therapists objectively stated that all of the interventions were not helpful to all of the children.
Although many of the children were willing to participate, she said that others were not interested in “doing anything.”

**Parental Involvement**

The parents, the medical director, and the county representatives all encouraged an increase in family involvement. Suggestions for ways in which this could be accomplished included creating an information group to be held prior to the start of each section of the trauma groups. This would accomplish two goals—to inform the parents that their children would be involved in the trauma groups and to discuss the activities that would occur in the groups.

Another suggestion involved the inclusion of a psycho-educational group for the parents regarding the effects of trauma on children. The psycho-educational group would also address ways in which parents and caregivers could be more supportive of their children. This type of group could also address the effects of their children’s traumas on the parents and caregivers.

A third suggestion entailed the implementation of a process group for the parents and caregivers that would operate simultaneously with the children’s trauma groups. If this type of group is implemented, the parents and caregivers would need to be fully informed that they would be required to willingly discuss their reactions to their children’s traumas and, possibly, talk about their own trauma histories.

A fourth, and simple, request involved the distribution of information sheets concerning the trauma groups and the effects of trauma. These sheets could relate
information such as the date and time of the groups. They could also contain introductory information regarding trauma and its effect.

Involving or including parents in deciding which of these options are implemented would strengthen the relationship between New Directions and the families of the children. Also, the parents may be more inclined to participate. Although a survey could be used to determine which form of involvement the parents and caregivers prefer, a more effective approach would include the creation of a task force of staff and parents who would discuss and report on this issue. The notion of including parents and caregivers in this process is supported in the literature (Steele & Raider, 2001; van Horn & Lieberman, 2004).

Environmental Concerns

The environmental concerns of excessive distractions interrupting the groups was addressed by the medical director and the child therapists. The physical structure of the building is, in part, responsible for this problem. Moving the trauma groups to alternate locations within the building in order to reduce the noise level outside of the room in which the trauma group meets is not an option due to the physical constraints of the building. Consideration could be given to carpeting some of the rooms or inserting sound proofing materials in the ceilings and some of the walls. This is a more viable consideration.

Exclusion

The teachers stated that they often were not informed concerning both organizational information concerning the trauma groups and clinical situations regarding
students in their classes who participated in the trauma groups. This issue of exclusion was identified by the teachers in their focus group sessions. Improved communication with the teachers would allow for positive interactions between the teachers and their students.

At the time of this writing, this situation remains an organizational issue that should be changed. The teachers are a viable resource for the overall functioning of the program, and they have intense daily interactions with the students. Increased communication with the teachers will benefit the entire program at New Directions.

Application of Interventions

The medical director stated that, at one of the monthly parent meetings, the staff responded to the parents’ questions about the Pretzel by explaining that it was introduced in the trauma groups, how it was performed, and why it was used. The medical director also reported getting feedback from a few of the parents regarding their use of the Pretzel to help their children feel more relaxed. The parents reported to the medical director that they encouraged their children to use the exercise when they saw their children getting upset or anxious. The medical director said that she saw marked “improvement” in some of the children who used the exercises.

Disclosure

When the PPSSTD study group examined the curriculum, they inquired about the manner in which disclosures were managed. I explained that disclosures were usually spontaneous and happened near the end of the series of trauma groups. Often, a contagion factor emerged whereby one disclosure would lead to another. For example, one latency
age male told the group he had been sexually abused. His disclosure was followed by a
deafening silence. Then, another male said it had happened to him, and a third male
responded, “Me too.” The therapists in the group informed the appropriate child or
adolescent individual therapist of what had occurred. The incident was later processed
with the child and further assessed.

Disclosure also had some negative aspects associated with it. Some of the
disclosures necessitated that a report be made to Child Protective Service (CPS). The
medical director indicated that, once such a report was made, some of the families
removed their children from the program. “We get too close,” she said of the situation. If
a CPS report was made as a result of disclosure and the child remained in the program,
that child would often stop talking about the threatening situations that had occurred.

**Boundaries**

The medical director placed strong emphasis on the importance of
boundary-setting by the staff. She insisted that the therapists communicate that message
to their clients, “I am not your friend, and I am not here to be your friend. I'm your
therapist. I am here to be the instrument of you getting better. I may not make you totally
better, but I am the stepping stone to your recovery.”

During the training sessions, there was some discussion of setting boundaries.
This important clinical concept, although emphasized by the director, was reinforced by
the staff training sessions. The children’s therapists spoke about boundaries and reiterated
the medical director’s stance when working with their clients. The therapists also differed
as to the kind of personal information they were willing to share with the children in
response to the children’s questions. Some of the therapists would not provide any
information of a personal nature, while others answered innocuous questions regarding
pets or hobbies. They all agreed, however, that information needed to be general and
minimal.

Research Question Two

What are the perspectives of the multi-disciplinary treatment team–professional
staff, parents/caregivers, and county program specialists–and expert practitioners toward
the trauma curriculum at the New Directions partial hospitalization program? Again, the
responses of the focus group participants and key informant interviewees were used to
answer this question. The sensory motor curriculum focused on intentional movement
and sensory awareness. Various forms of movement were applied in the curriculum. The
use of movement, one of the sensory processes in the mind-body relationship, is
supported by research in the areas of attachment theory (Schore, 2000; Siegal, 1999) and
neuro-biology as it relates to trauma effects and development. Additionally, movement is
the basis for the Brain Gym® exercises utilized at the beginning of the trauma group
sessions and is an essential aspect of one’s learning (Hannaford, 1995).

Sensory Motor Exercises

Overall, the therapists agreed that the three Brain Gym® exercises performed at
the beginning of each trauma group session provided structure and focus for the groups.
The format was predictable and explanations for doing the exercises were frequently
stated within the trauma groups. Leadership emerged within the groups where the
children would volunteer to lead the individual exercises, this role would rotate among
the membership. Also, the therapists commented on a phenomenon that evolved within and outside of the groups. There were times when the participants would know that a peer was not doing well. They would suggest to the child that they take a break and do the Pretzel. Additionally, within the groups, some participants would voluntarily take a “timeout” to perform one or more exercises and regroup. This “timeout” may have been concerned with a pre-group event or with a situation that occurred during the group session. When the child rejoined the group, the therapists offered the group members an opportunity to process the situation. The therapists also noted that they observed students sitting in their academic classes, performing the Pretzel or another exercise. According to the therapists, the nurse, and the medical director the students were willing to do the exercises without adult prompting.

It was agreed that the Pretzel was embedded into the culture of the program to the extent the one of the clinicians with a sense of humor remarked, “Five years from now, we’ll be doing ‘Duckies and Bunnies Therapy.’ They will still be doing the Pretzel.” Another child therapist offered that a child from another county had demonstrated the Pretzel to him and called it as such. The parents report seeing their children doing the Pretzel at home, and the nurse reported seeing written dialogues in the journals regarding the exercises.

Some of the exercises required a higher energy level than others. members of the PPSSTD group addressed concerns for about youngsters being able to transition from high energy and activity levels to regular classroom activities or to focus on nonphysical
activities within the trauma groups. None of the participants in the other focus groups or key informant interviews offered this as an issue they experienced.

Support for Continuation of the Trauma Groups

It was the consensus across all focus groups and key informant interviews that the trauma groups should be continued at New Directions. It was stated in the focus group with the adolescents’ therapists that the trauma groups were a “fit.” Another participant stated that the focus groups “had become an important part of the New Directions program.” A member of the children’s unit remarked, “I think we are invested in trauma.” The teachers endorsed continuing the trauma groups as they had seen improvements in certain children and attributed the progress to involvement in the trauma groups.

The parents also indicated a desire for the groups to continue. For instance, one mother said that it was “really great” that the trauma groups were being conducted in the program along with the other program components being offered for the children.

Another parent said “I can’t think of a better place for these groups.” This was followed by yet another comment, “The groups belong here.”

Trauma Groups Caused Changes in Student Behavior

While the adolescent therapists witnessed and reported negative symptoms (called affect dysregulation) including anxiety, defiance, and dissociative episodes, they also reported that these behaviors “de-escalated” over time in frequency and intensity. They described these negative symptoms as occurring intermittently and concurred that, in the end, the adolescents were “a lot better off” for having gone through the trauma groups. On the other hand, the trauma sessions awakened many feelings for the students. One
therapist put it this way, “A lot of behavior problems came out of trauma too.” The adolescents also demonstrated regression—several experienced flashbacks, some became more defiant, while others would use inappropriate language in the hallway following group. One of the adolescent therapists provided this insight, “The kids were unable to deal with all that was coming up for them.” Even though the therapists witnessed and reported negative behaviors, they noted a process “saw them [the students] cope and deal and feel safe and deal with some of the unpleasant feelings . . . They were able to do that in a way that . . . de-escalated in time and, actually, in the end, they were a lot better off.” The regressed behaviors were reported as intermittent rather than constant, “It was on and off and then it just left again.”

With the guidance and support of the therapists, a pattern emerged in both the children’s and adolescents’ groups in that one student would volunteer to lead or start one of the three opening exercises. Two other students would lead the other two exercises. The children were quick to point out any procedure that was out of order or omitted. Different children would be selected as “volunteers” each time the trauma groups met. Initially, the adolescents resisted doing the exercises, particularly during the first week of the trauma groups; their attitudes began to change during the second week. The children, however, were more spontaneous about this process.

Several individuals from multiple focus groups and key informants interviews reported that the application of interventions was observable. The therapists and medical director even reported that children who had gone through the trauma groups taught
others who were not involved in the trauma groups to perform the Pretzel or Brain Buttons.

Client Growth

One therapist said that, from being in the trauma groups, the participants could accurately identify notions such as trauma, flashbacks, and grounding. One therapist commented that client growth was “pretty impressive.” She also reported seeing the children help each other. In one example provided by the therapist, two girls began a discussion about sex. Another girl began to shake. One of the children in the group asked “What do you do when this happens?” The children then began to give the shaking girl cues such as “Grab onto your chair.” The help the children offered was successful.

Several of the children and adolescents rotated through the groups more than one time. This issue was addressed by the PPSSTD group. A few members ran adolescent trauma groups at a rape crisis center and remarked that several of the adolescents in their agency had repeated the group and gained from the experience. The medical director and an adolescent therapist spoke of a female adolescent who went through the groups many times. She had a complex trauma history and her level of functioning was delayed, she required many extensive restraints and was not well liked by her peers. Initially, it was difficult for her to stay on task. After repeating the trauma group numerous times, her peers began talking to her, she was more appropriate in her interactions with others, her art work went from the use of one dark color to the use of varied colors, and her drawings became more elaborate. One of the adolescents’ therapists stated, “We now have a young lady who is 100% better.” The medical director stated that the client was much improved
regarding affect regulation and that the use of the exercises was instrumental in her improved level of functioning.

**Research Question Three**

Have the perspectives of the multi-disciplinary treatment team–professional staff, parents/caregivers, and county program specialists–changed concerning the concept of trauma and its effects? This question was also answered by findings derived from the focus groups, individual interviews, and researcher observations. Research in the areas of developmental psychopathology and the human stress response supported this area of inquiry. In considering trauma effects, discussing the problem, by itself, cannot change the sensory results. However, cognition is useful in connecting to an awareness of an emotional state through a sensory reaction. A characteristic of the trauma curriculum was body awareness, which assists in managing affect dysregulation, a common problem seen in the children at the partial program. Teaching the children how to do the exercises and when to apply one of the movement interventions assisted in avoiding emotional outbursts and aided in the healing process.

*Expanded View of Trauma*

The lived experiences of the participants indicated that many of them expanded their view of trauma with more depth and sustenance. Several of the children’s therapists and the student teacher believed that trauma was abuse and rape. Overtime, their understanding of trauma grew. The teachers, in their first focus group meeting, provided examples, other than abuse or rape, of traumatic events. One of the children’s clinicians spoke of a client who survived a serious car accident along with family members in which
no one was seriously injured; however, the client was affected with nightmares, sleep disturbances, intrusive images, withdrawal from friends, and anxiety. This situation “opened her eyes” to the many forms of trauma. Both the therapists and the parents said that the children identified removal by CYS (Children and Youth Services) and the police as the “worst” experience they had ever had. Both groups commented that the children did not identify the action that precipitated the removal as terrible; rather, they identified the removal as traumatic.

One individual made a significant statement, “People used to talk about trauma work, and I thought ‘Why don’t they just bleed them with leeches?’ I was wrong. I was dead wrong.” This therapist further commented about the methods used in the trauma groups changed his mind and that he sees that it can work, “It works A number one in spite of my sarcasm.”

Another example of an expanded definition of trauma was presented with the following impression of an adolescent therapist, “I personally viewed it [trauma] as something akin to voodoo, and I no longer do.” One child therapist put it this way, “I see trauma as more broad than previously. Events which I formerly did not see as ‘traumatic’ and now I see them differently as truly affecting the children in traumatic ways.” Several clinicians stated they had gained an increased understanding of the connection between the children’s behavior that they observe and something that has previously occurred. The therapists also discussed having an increase in their tolerance, being able to pull back from their frustrations, and having more patience with the children.
The nurse said that she had been able to reconsider some of the children’s conditions. She indicated that there were many cases of ADHD and that a few children had not improved on stimulants. She presented that some of the children who are not improving who are diagnosed with ADHD could be suffering from past traumatic experiences or may have family histories of undiagnosed mental health problems. She advocated the case consultations as an area of growth for her which guided her to reconsider and further assess by asking different questions of the family of those children, and to continue to explore those areas in her future assessments. She also addressed the awareness of the long-term consequences of early trauma.

The county representatives reported that they had grown in their comprehension of trauma effects due to their job requirements. They said that, often, a need arose to help children deal with traumatic stress. While their clinical growth did not occur from involvement in the trauma program at New Directions, they attributed it to their clinical experiences and said that it made them “more sensitive” in asking questions of their clients. They also were supportive and enthusiastic concerning the implementation of the trauma curriculum. They, in fact wondered if “there had been a change in the staff’s understanding of trauma?”

*Vicarious Trauma*

Another aspect of trauma recognized in the research is the traumatic stress that evolves from witnessing domestic violence or other violent acts. It also is seen in helping professionals who listen empathically to repeated accounts of traumatic events related by their clients. This type of trauma is called vicarious trauma. The repeated stories can
internally affect helpers and change their world view. Vicarious traumatization also is “marked by significant personality changes in those it affects” (Jankoski, 2002, p. 179).

The notion of vicarious trauma was addressed by the children’s therapists as they commented on their heightened awareness of the effects on their clients caused by witnessing violence or adult substance abuse. They also discussed the changes in their clients’ world views.

Several therapists voiced the difficulty they personally experienced in hearing the “awful stories” their young clients told them. They reported getting upset with the children who kept repeating their stories to different therapists or groups, believing the children were being “manipulative.”

The children’s therapists described reactions to various kinds of assaults by the children—being kicked, being spit at, getting bit, or verbally assaulted—and, at times, requiring medical evaluation due to the kind or severity of the assault. They reported that, as a group, they had learned “to support each other” through listening and, occasionally, doing things together. At times, after repeated assaults from the same child, the therapists question themselves and become frustrated as “nothing seem[ed] to work” Some reported that “their significant others or family members [did] not understand.” They also stated that by supporting each other, they had “become a better team,” allowing them to return to their jobs. They also presented the value they placed on feedback from their peers when they handled a difficult incident.

The psychiatric nurse remarked that in an environment when staff members are constantly working with traumatized individuals, vicarious traumatization needs to be
constantly evaluated. The nurse stated that the entire staff is exposed to overwhelming situations on a daily basis. “Had you [the researcher] never addressed this with us, we never would have realized what does happen.” She admitted that she “does not know what to do with some of the feelings she has” a result of working at the partial hospitalization program.

**Impact on Early Development**

The nurse at New Directions related that, through the trainings, she learned about “the profound impact of early trauma on development.” She said she did not realize the intricate paths traumatic events can create. She also stated, “I did not know repeated exposure to traumatic events can have a long-term effect,” with symptoms that masked those of ADHD.

It is my opinion that an enhanced understanding of traumatic stress resulted in clinical growth of the therapists and contributed to improved treatment for the children. An example of this is presented with the following impression of an adolescent therapist, “I personally viewed it [trauma] as something akin to voodoo, and I no longer do.” Another therapist indicated that she believed it takes a lot of understanding to realize what is going on with the groups, “You can’t do a single group intervention and expect that it is going to take [immediate] effect.”

During the teacher’s focus group, the researcher inquired if they had noticed any changes in their perceptions or understanding of disruptive behavior in the classroom. One teacher stated that, “I try not to add to their abuse.” Several of her colleagues agreed.
Another teacher commented, “There is a way of doing it [redirecting] . . . without berating them [the students].”

Recommendations and Implications

The results from this study indicate that the Sensory Motor Trauma Groups have had a profound impact upon the trauma program at New Directions. (It should be noted that, as of this writing, the trauma groups have continued to run and, for the first time, the groups were held during the summer program in 2004 without the researcher being involved as a consultant. The groups are scheduled to run again in the 2004-2005 school year.) It is my hope that the staff will continue to assess the needs of the youth involved in the groups and adapt the curriculum by changing the order, by making modifications, or by adding interventions of a sensory motor nature. Additionally, ongoing bimonthly case consultations need to continue at New Directions to allow the entire staff to meet and review clinical issues, cases, or problems in the classrooms or groups. At the same time, the mini training sessions that are attached to these consultations need to continue in order to perpetuate further clinical growth, particularly in managing affect regulation.

Ongoing efforts are indicated in enhancing communication among the various disciplines (teachers, the medical director, the psychiatric nurse, clinicians, and administrative staff) at New Directions so that all constituents can be heard. Enhancing communication among the constituents will only add to the integrity and the services to the children who attend this program.

Through the dialogues in the various focus groups, the staff reported receiving snippets of information regarding trauma throughout their academic training in
undergraduate, as well as graduate, school. This was true regardless of the individual’s training—child development, social work, counselor education, or psychology. In contrast, the same staff provided clear descriptions of their increased understanding of the effects of trauma on children and adolescents through the work accomplished in running the trauma groups, the case consultation meetings, as well as formal in-services and outside conferences. The medical director clearly supported this statement when she offered that her staff had improved in their assessments of the children and had correctly identified dissociative episodes in their young clients. As one of the county representatives put it, they “have more tools in their toolbox.”

Another implication of this study comes from the parent voices who strongly advocated for more involvement in the trauma groups. Without knowing the technical terms for what they advocated, the parents suggested a parent psycho-education group, a parallel process group, or an information group for the parents prior to the initiation of the children’s groups. Several parents suggested information sheets concerning the trauma groups and the effects of trauma on children be made available to them. They acknowledged that they had been informed in one of several ways that their children were participating in the groups. They also voiced a desire to help their children at home and needed more information regarding the exercises and other interventions in order to do so. The implementation of parent groups came as suggestions in the parent focus groups and the key informant interviews with the county representatives and the medical director. Current research supports this notion. A staff person would be able to construct a
group that complements the child and adolescent trauma groups, and this researcher supports the involvement of the parents in the planning of such an endeavor.

Culture evolved as an important aspect of the data collected in this research. The parents spoke about the distress they saw in their children and the participating parents very much wanted to further support and understand their children. According to Lieberman and van Horn, “trauma often serves as a catalyst for strong family beliefs and traditions, often rooted in cultural values, about ways of helping the child through the recovery process” (2004, p.119). Trauma that occurs to children as a member of a group as compared to trauma in a parent-child relationship has different outcomes and effects developmentally on a child (Lewis & Ippen, 2004).

In doing this research, the researcher learned that participants responded to questions with anecdotes as a way to share their understanding of the process they had experienced in their clinical growth. I grew in my ability to not only listen intently but to also appreciate the meaning of the stories that the various participants of this study presented. Clearly, it was a process I came to value in that story telling provides information about the context of the situation and provides insight into culture. It is recommended that the staff be helped in translating these anecdotes into professional jargon. This could be accomplished in the case consultation meetings with a properly trained consultant.

The therapists in this study were sensitive to the meaning that the children and adolescents held for the trauma and stressful situations in their lives. A significant realization included the therapists’ insights that much was revealed as the children drew
their safe place and then described them to the group. This was in contrast to the therapists’ observations of “the lack of affect” displayed by the children as they described “the most shocking events in their young lives.”

Knowledge of the family background and the context of each child’s family system was helpful information to the clinicians in relating to the children and adolescents with a heightened level of sensitivity concerning cultural differences. The common issues of poverty, unemployment, limited resources, inadequate housing, community violence, unemployment, parental substance abuse, mental health of the parents, and the young age of many parents contribute to complicating the effects of trauma in children.

The theoretical orientation of the curriculum considers diversity issues while, at the same time, finding ways to manage affect regulation. This often is a challenge. Many of the activities introduced were intended to keep the attention of the children focused and to allow alternative ways of self-expression through drawings, art projects, movement activities, music, and discussions. While the teachers and the expert practitioners identified transitional objects as helpful, pens and stickers were the items that held meaning for the children and adolescents. This must be respected.

The therapists also need to be aware of cultural biases and differences. An example in this study relates to the county representatives’ reactions to parents with whom they have spoken who did not believe that the sexual abuse suffered by their children from a family member would affect their children.
Hypotheses Generated by This Study

Several findings of this study suggest hypotheses for further examination. Each of these areas are discussed categorically below, followed by a section that identifies the specific hypotheses generated by this study.

Treatment Approach

As a result of the research conducted at New Directions Partial Hospitalization Program, several hypotheses were generated. One of these hypotheses deals with the approaches taken by clinicians in treating disruptive behaviors exhibited by children and adolescents. The most common and effective approach, cognitive behavioral therapy, deals with the youth’s thoughts concerning the event and identifies and confronts distortions that might be present. This, in turn, changes the affect in the child or adolescent. Cognitive behavioral therapy has received the “strongest empirical support” (American Academy of Child and Adolescent Psychiatry, 1998, p. 49) in studies dealing with abused children. While this approach is effective, the cognitive behavioral approach is compromised when a child’s behavior is part of an identified trauma history.

Academic Training

Clinicians, from their own experiences, shared two very important facts with me. First, trauma theory and trauma interventions typically were not included in their academic training programs. Second, the clinicians admitted operating from narrow perspectives with regard to trauma and its effects. Both the therapists who were interviewed in the focus groups and the medical director of New Directions stated that pre-service academic training programs did not prepare therapists for understanding the
effects of early trauma on development nor the remedies to be taken should early trauma be identified.

As a result of the data collected in this study, I hypothesize that academic curricula should incorporate the study of the long-term effects of trauma on development. This hypothesis is supported by the work of Cicchetti and Toth (1995). Further exploration of the need for academic instruction focusing on trauma theory, assessments, diagnostic criteria, and treatment protocol are indicated. Clinicians without training in the area of trauma may observe impulsiveness, poor concentration, and defiance in their clients and assume the observed behavior is indicative of Attention Deficit Hyperactivity Disorder (ADHD). Behaviors often exhibited by children and adolescents who have suffered traumatic situations cross several diagnostic categories including Attention Deficit Hyperactivity Disorder, Reactive Attachment Disorder (RAD), Bipolar Disorder, and Post Traumatic Stress Disorder (PTSD) (Levy & Orlans, 1998).

*Training of Supervisors*

A related hypothesis concerns clinical supervision. If clinical supervisors have little or no understanding of the long-term effects of trauma, they will be handicapped in supervising clinicians. This will then have a ripple effect, eventually affecting the treatment of the children and adolescents for whom the clinicians and, in turn, the supervisors are responsible.

*Application of Curriculum Across Cultures*

Not only is the study of trauma important, an understanding of how various cultures view and adapt to the effects of trauma also is important. The child therapists
reported that several children graphically described traumatic events in their lives and, at the same time, displayed no affect. It is possible that traumatic events are so ingrained in their everyday lives that their emotionless reactions have become part of their cultures. They are virtually blind to the shock displayed by others when they describe such events. Although not all youngsters exposed to traumatic events are traumatized by the events, the events can continue to affect their world views. This must be taken into consideration.

_Sensory Motor Focus of the Curriculum_

The next hypothesis generated by this study focuses on the sensory motor aspect of the curriculum. As a result of the sensory motor interventions used at New Directions, the clinicians reported that the children and adolescents described increased awareness of body sensations such as tingling, tightening of muscles, breathing patterns and rates, body temperature, heart rate, and feelings of being tied up in knots. As a result of the discussions with the clinicians, teachers, and psychiatric nurse, the trauma curriculum proved to be quite illuminating regarding the prevention and decrease of hyperaroused states. Through the curriculum, the clinicians learned to implement a variety of interventions with the children and adolescents that contributed to the healing processes in their traumatized and overly aroused clients.

The healing process begins when a child or adolescent learns to self-regulate using the interventions intended to de-escalate arousal. This healing process was reported by parents as well as clinicians and other staff personnel. They observed the children and adolescents using the interventions without direction from anyone. They also suggested that their peers use the interventions in order to relax or calm themselves.
According to the literature (Hannaford, 1995; Perry, 1999), by redirecting or avoiding a hyper or hyparoused state, less cortisol and other hormones are emitted onto the central nervous system and the body is able to calm and bypass the stress response, thus lessening further negative impact on the child and allowing the child to focus and learn. The cortex then functions to allow the child to learn. It is hypothesized that if children are able to self-regulate more effectively, the therapists will then be more effective in their treatment of these children and the parents will be more supportive of their children as conflict lessens.

**Adult Application of the Curriculum**

A related hypothesis involves the application of a sensory motor approach with traumatized adults. Given that the previous hypothesis is viable, teaching adults with PTSD to self-soothe through increased body awareness by utilizing sensory motor exercises can circumvent dissociative episodes and flashbacks in those adults. This idea was expressed by both Levine (1997) and Ogden and Minton (2000). They suggested that releasing the “stuck” and stored reactions to trauma would then allow the trauma to be processed on a cognitive level, leading to relief and desensitization for the client. Until the sensation is calmed, cognitive processing by itself may not alter the body sensations typically experienced by a traumatized individual. Several of the expert practitioners interviewed in this study articulated a desire to use some of the interventions with their adult trauma survivors. They were particularly interested in the Pretzel and the drawing interventions.
Cross-Cultural Application

Another hypotheses related to the research is the cross-cultural applications of this curriculum. The sensory motor approach is not language-based. Rather, it is based on the neurobiologic aspects of trauma. Regardless of the culture in which one lives, the internal effects of trauma are the same. However, drawing and movement are nonverbal activities that are expressed across many, if not all, cultures. Although the drawing of a “safe place” may differ from country to country due to geographical changes, the concept of a “safe place” has a universal applicability. Although the music chosen by children in Africa might differ from that chosen by the adolescents in the New Directions program, the concept of using music to express how one feels cuts across multiple cultures.

Children limited by the inability to read English or any other language would not be hindered by the application of these sensory motor interventions. Drawing and movement, both nonverbal activities, are can be implemented in and adapted to a variety of cultures. However, I hypothesize that the internal processing of these nonverbal activities will be the same regardless of the culture in which they are applied. Therefore, the trauma curriculum can be adapted to and used in various cultures—urban or rural areas of the United States, underdeveloped countries, or other industrialized nations.

Poverty as it Relates to Trauma

An additional hypotheses concerns poverty, which appears to exacerbate trauma. The focus groups identified both poverty and family systems as psycho-social culture themes that affect the children in the New Directions program. A teacher reported that one of her students had lived in a car for a period of time; a parent described having to
carry water into their trailer, which lacked a commode; and the nurse and a therapist described a thick green mold that covered the peanut butter sandwich a young child brought from home.

This study occurred in Fayette County, the most impoverished rural county in the state of Pennsylvania, where 29.9% of all children under the age of 18 live in poverty (Pennsylvania Partnership for Children [PPC], 2001) and where 41% of all children are on medical assistance—the highest rate in Pennsylvania (PPC, 2001). The longer a child lives in poverty, particularly during infancy and the preschool years, the more pervasive the effects on the child (Brooks-Gunn & Duncan, 1997). Poverty often is accompanied by low income, single-parent households, limited resources, and poor access to health care. Impoverished children have higher percentages of low birth weights and respiratory illnesses (PPC, 2001). They also are prone to lead poisoning (Brooks-Gunn & Duncan) and their immunizations often are not current. These impoverished living conditions and the stress that parents in such living conditions experience contribute to neglect and other forms of maltreatment.

Specific Hypotheses Generated

1. The prevalent therapeutic approach, cognitive behavioral therapy, taken in most clinical situations is not always the most efficacious when treating disruptive behaviors exhibited by children and adolescents who have been traumatized.

2. Academia training in counselor education needs to include courses on trauma theory and its effects on development.
3. Clinical supervisors with little understanding of trauma effects will have a negative impact on the treatment of children and adults with trauma histories because they are unable to properly supervise the clinicians for whom they are responsible.

4. The impact of culture on trauma reactions needs to be considered because there is a lack of affect displayed by many individuals in describing personal traumatic events.

5. Due to the goal of self-soothing, a sensory motor approach to the treatment of trauma may improve affect regulation in the child, which will then have a positive effect on the treatment offered by therapists.

6. Providing a sensory motor treatment approach for adults survivors of trauma, including self-soothing techniques, will circumvent or decrease dissociative episodes and flashbacks.

7. The sensory motor orientation of the trauma curriculum can be applied across multiple cultures and diverse populations due to the movement and expressive aspects of the curriculum.

8. Living in poverty in an ongoing basis exacerbates the effects of traumatic stress.

Implications for Future Research

There are several implications for future research. The PPSSTD group suggested running the curriculum in a school district with a control group of children who were not traumatized. They suggested an additional study using quantitative methods.
As this curriculum was written so that it could be adapted to various settings, including other partials and residential treatment facilities, a multi-case qualitative study in combination with a quantitative study could inform the field further concerning traumatized children. Additionally, a qualitative study could be conducted in order to determine the manner in which and degree to which various cultures shape responses to trauma.

Another suggested change involves the organization of the focus groups. A focus group with lead therapists and lead teachers would enhance the study by obtaining an additional perspective. This would also give the therapists and teachers not in leadership positions greater freedom in expressing themselves.

It is also recommended that, should this study be replicated, a co-researcher be used to increase the depth and intensity of information collected. The co-researcher would validate the findings reported by the primary researcher, serve as a note-taker, and observe and take note of non-verbals expressed by the participants.

I firmly believe that the Diagnostic and Statistical Manual (DSM) should contain separate criteria for the diagnosis of Posttraumatic Stress Disorder and Dissociative Disorders in children and adolescents. While this recommendation is supported by others in the field, it is important that it become more than a recommendation. Further research could therefore assist in such an endeavor.

Implications for Counselors

This study reinforces the need for counselors to enhance their professional practice in several areas. They must be more knowledgeable regarding trauma and its
effects on developing youth. They must be given the skills to improve their assessment skills and treatment approaches, including expressive arts and movement. Finally, they must be given opportunities to continue their ongoing training, which may include diversity sensitivity, cultural differences, and trauma effects.

*Implications for School Officials and School Counselors*

The results of this study indicate the important relationship that exists between children and the school environment (friends, teachers, coaches, teachers, principals, teacher aides, bus drivers, and custodial staff). School officials are important in the recovery of children who have been traumatized. Constant encouragement, provision of a safe environment, delineation of school rules, and sensitivity to diversity issues are all required.

School counselors are a positive resource for all members of the academic community especially teachers. The counselor can assist teachers in understanding the effects of trauma and the possible disruptions it causes in the learning environment. In addition to educating the teachers, the counselor must be skillful in providing classroom interventions the teacher can implement to assist a child in becoming successful. The school counselor must be knowledgeable of the community resources available to parents and families, be instrumental in providing parents ways to enhance their support to their children.

*Implications for Counselor Educators*

This research clearly speaks to graduate schools of education to include trauma theory in the course work at their institutions. This could include a specific course that
centers on trauma effects or implements trauma theory in one or more of existing curriculums. While the effects of trauma are seen in developmental problems or delays, in behavior problems in the home, schools or community, as well as in relationships this construct is seldom introduced in school of counselor education. Additionally, for those institutions having doctoral programs in counseling there is a need to train supervisors in understanding the complexity of providing trauma services and to address the vicarious trauma that can overwhelm clinicians who choose to treat this at times emotionally taxing population.

Implications for Insurance Companies

Insurance companies authorize payments for services. Therapists, at times, need to request more coverage for their clients after the allotted visits are used. Such requests are made through Title 150. In general, diagnoses of depression and anxiety are granted additional coverage for extended visits. However, it is the opinion of some insurance companies that there is little chance of improvement for those with PTSD. Therefore, requests for additional coverage for this diagnosis are usually denied. This study indicates that the use of sensory motor interventions may allow for shorter times in treatment and, more importantly, lead to improvement in patients.

Limitations of the Study

One major concern that limits this study is the degree of researcher bias. I wrote the curriculum, implemented it, trained the staff, and ran the focus groups and key informant interviews. As a result, questions may be raised concerning the trustworthiness
of this study. This research bias was, however, offset by discussion with the dissertation committee, interested colleagues, and meeting with the New Directions staff.

A second limit to this study is that it occurred in one setting in an impoverished rural area. A third limit of this research concerns the effectiveness of the interventions. No information was provided to indicate which interventions were more helpful to the children versus the adolescents, which interventions need further modification, and which need to be discontinued. The children and adolescents were not directly involved in this study due to their vulnerabilities and their fragile conditions.

Summary

The last fifteen years of my professional career have been focused on the treatment and assessment of trauma effects, first on adults and, most recently, on children and adolescents. Research regarding the effects of trauma on children has only been recently done. However, there is a greater amount of information on the effects of trauma on adults. This must be balanced.

After many years of clinical practice and much discourse with professionals who specialize in treating trauma, it is clearly obvious that several gaps exist in the area of trauma. These include the need to inform the public, the need to educate and train future professionals regarding the long-term consequences of trauma, and the need to improve treatment modalities for this population.

While trauma focused CBT is the treatment of choice, one modality cannot fit all situations. The sensory motor approach offered a focus on the body and mind connection
in the treatment of trauma effects. These interventions are an extra tool that can be used to assist in affect regulation in this population.

Closing Thoughts

In closing I would once again give voice to the youth about whom many participants in the study spoke by echoing the words of one of the parents, “Ain’t no one gonna’ learn if they’re upset by what has happened to ‘em. Head don’t work that way. They gotta talk somewhere where people like the counselors here understand.” This same parent offered a statement for those in academia responsible for training future clinicians and for active therapists in the field, “Them kids know who gets it and who don’t. We’ve talked to some dumb people [therapists] who don’t get it.”
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APPENDIX A

Definitions
Affect regulation refers to the way in which an internal emotion is externally expressed and managed.

Attachment refers to the “bond” that forms between an infant and mother. It also is the foundation from which the mind develops. Attachment is formed by the repeated interaction between an infant and a primary caregiver, fostering a connection between them during the first year of life.

Attachment disruption is an extensive and unexpected separation from the attachment figure, which disrupts the child’s assurance regarding the availability of the attachment figure.

Boundaries are established limits. For the comfort and safety of the client, the therapist, and other outsiders, behavioral boundaries often need to be established. These limits may affect a range of issues including details of personal and therapeutic interactions, such as the length of therapy sessions; appropriate touching; number and duration of phone calls; and prevention of assault and suicide.

Brain Gym® is a program of exercises created by Dr. Paul Dennison to promote full brain activity, with the intent of improving attention and focusing learning through movement.

Brain plasticity refers to the process of change in the brain.

Brainstem refers to that part of the brain that develops in utero. The brainstem is fully operational at birth and is most sensitive prenatally.

Child is a term used to refer to a human being 18 years of age or younger.
Child abuse is any recent act or the failure to act by a perpetrator causing purposeful and serious physical, sexual, or emotional injury to a child under the age of 18 years. It also includes physical neglect of the essentials of living including, but not limited to, medical care and development impairing the child’s level of functioning.

Child Abuse Prevention and Treatment Act (CAPTA) is the name given to the 1974 federal legislation that governs child abuse programs in all 50 states of the United States. The act provided for funding to states in order to meet nationally established standards for identifying, reporting, and responding to child abuse and allegations of neglect.

Child Protective Services (CPS) are those services provided by the Department of Public Child Welfare. It also refers to each county agency within all 50 states which is responsible for handling child abuse cases.

Cognitive behavioral therapy is the name given to the treatment approach that focuses on observable behavior and on the thinking or beliefs that accompany the behavior.

Containment refers to the ability of individuals to manage their overwhelming feelings. It is a process that involves being able to detect a symptom, consciously postpone dealing with the intrusive symptom, communicate with others concerning the symptom, set it aside (contain it), and revisit the symptom later.

Corpus callosum refers to the part of the brain that serves as a connector between the left and right brain hemispheres.
**Cortex** is that part of the brain that actively develops during childhood and is functionally mature in adulthood. It is the area of the brain in which the highest level of processing occurs. The most plastic portion of the brain, the cortex governs reasoning, problem solving, abstract thinking, and secondary sensory processing.

**Counter-transference** refers to a therapist's conscious or unconscious emotional reactions to a client. Therapists must monitor their reactions to their clients in order to minimize the impact of clients’ materials on the therapeutic relationship and treatment.

**Developmental psychopathology** is the study of psychology, sociology, psychiatry, and neuroscience with the purpose of improving the understanding of normal and abnormal human development over several domains of functioning including affect, cognition, interpersonal relationships, school adjustment, and biology.

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is currently in its fourth edition (*DSM-IV*, 1994). This manual is published by the American Psychiatric Association and contains standard definitions of psychological disorders. *DSM-III-R* refers to the third edition, revised, of the same manual; it was published in 1987. The diagnostic categories referred to in the trauma literature published in the late 1980s and early 1990s are those from the *DSM-III-R*.

**Diencephalon** is also referred to as the midbrain. This portion of the brain develops rapidly during infancy and matures during childhood. It regulates primary and secondary motor controls.
**Dissociation** is a trance-like state in which consciousness, state of mind, and information processing become fragmented. It includes depersonalization, derealization, and psychogenic amnesia.

**Dissociative Disorders** refers to a group of psychiatric conditions with disruptions in the integrated functions of consciousness, memory, identity, and perception of the environment. There are five types of Dissociative Disorders listed in the DSM-IV: Dissociative Amnesia, Dissociative Fugue, Depersonalization Disorder, Dissociative Identity Disorder (DID/MPD), and Dissociative Disorder Not Otherwise Specified (DDNOS).

**Dysregulation** is the interruption of normal functioning.

The **Ecological Theory of Development** was originated by Uri Bronfenbrenner. He emphasized the interactions between a child and the environment in which the child lives, focusing on how the child perceives the environment.

**Empathy** is the ability of a person to put oneself into the psychological frame-of-reference or point-of-view of another, to feel what another feels.

**Empowerment** gives the client a power stance rather than a victim stance.

**Explicit memory** refers to consciously recalled facts or events (knowing that) which have verbal components. This is the form of memory used, for example, when a person recounts the events of the workday or school day. It is also referred to as narrative or declarative memory.

**Expressive therapies** are specific therapeutic techniques that facilitate the expression of feelings through drawing or movement. Examples include dance, art, and poetry
therapy. They are most often used as adjunctive therapy to gain access to feelings or memories, expressive therapies are increasingly used for primary treatment in trauma cases. Since traumatic memories may be stored on sensory motor or visual levels, the use of these therapies may access memories not usually available through talking therapy.

**Eye Movement Desensitization and Reprocessing (EMDR)** was developed by Francine Shapiro in 1989. It is a multi-component process used in the treatment of trauma and PTSD. It facilitates the unblocking of traumatic memories that are stored, stuck, or wedged in neuro-pathways. It encourages changes in thoughts centered on traumatic events and instills positive cognition, coping skills, and adaptive behaviors.

**Grounding** refers to a reality-based awareness in the here-and-now. It involves a sense of connectedness to oneself and one’s environment.

**Hyper-arousal** refers to an individual’s excessive sensitivity to sounds and sights in the environment. The individual who is hyper-aroused will scan the environment expecting danger and experience feelings of being “keyed-up,” “on-edge,” or rage. Rapid cognitive and emotional processing, as well as intrusive memories, can occur in the hyper-aroused individual.

**Hyper-vigilance** in an individual involves a heightened sense of awareness in which the individual scans the environment to ensure survival. Hyper-vigilance is a symptom of PTSD.
**Hypo-arousal** is a state in which an individual conserves bodily energy. It is evidenced by a decrease in heart rate, a feeling of numbness or shutting down, and a slowing of responses. Hypo-arousal can lead to dissociation.

**Imagery** refers to one’s use of the imagination to manage stress responses and feelings.

**Implicit memory** refers to the behavioral knowledge of an experience (knowing how) without the conscious recall or verbal components associated with the experience. Driving a vehicle, riding a bicycle, or reading are examples of skills which people implicitly remember how to do without consciously remembering the steps involved in the activity. This type of memory is almost always irretrievable in word form. Implicit memory also is referred to as habit memory, procedural memory, or sensory motor memory.

**Impulse** is an action urge.

**Intervention** refers to a strategy used to stop or change a specific situation or condition.

**International Society for the Study of Dissociation (ISSD)** is a nonprofit professional association organized to promote research and training in the identification and treatment of Dissociative Identity Disorder (DID) and trauma. ISSD provides professional and public education about DID and other dissociative states and serves as a catalyst for international communication and cooperation among clinicians and researchers working in this field.

**Limbic** refers to that area of the brain which develops actively during early childhood and reaches its mature state during puberty. The limbic area contains the memory
systems and plays a key role in attachment, emotional and affect regulation, and primary sensory integration. It complements the brainstem.

**Movement** is a sensory motor process that contributes to a child’s understanding of the environment. It is essential for learning to occur and important in integrating and anchoring new information into one’s neural network.

**Neglect** is the failure of a caregiver to provide necessary care—age appropriate supervision, education, medical care, food, shelter, and clothing—to a child, where the action results in harm to the child. Neglect is the most substantiated form of child abuse.

**Neuron** is another name for a nerve cell.

**Neurobiology** is the study of the way in which neurons operate, how the brain functions, and what occurs in the brain as it develops. Neurobiology also includes the study of the relationship between maltreatment and symptoms observed in the maltreated individual.

**Neural systems** are composed of nerve cells (neurons). They regulate the sympathetic and parasympathetic systems, intensity of vigilance, mood, attentiveness, and sleep patterns in an individual.

The **Office of Children, Youth and Families (OCYF)** is an agency within the Department of Welfare responsible for establishing state policies and procedures regarding child abuse reports. OCYF also provides technical assistance to county-level offices.
**Ontogeny** is the study of the growth of the developing brain and self-regulation in humans.

**Partial hospitalization program** refers to an intense level of treatment for children and adolescents who have serious mental health issues that interfere with their functioning at school, in the home, or within the community. The program includes both school and mental health components. While in the program, the child continues to live at home or within the home community. Children are taken to the program facility five days each week and remain there for an average of six hours each day. The overall length of stay in the program varies depending on the individual child’s needs.

**Post Traumatic Stress Disorder (PTSD)** is a psychiatric diagnosis that occurs after the experience of or witnessing of life threatening events. It includes avoidance, numbing, hyper-arousal, and re-enactment. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached. The severity of the symptoms can significantly impair the person's daily life. Biological changes are exhibited in individuals suffering from PTSD.

The **Pittsburgh Professional Society for the Study of Trauma and Dissociation (PPSSTD)** is an affiliate organization of the ISSD.

**Psychological trauma**, also referred to as relational trauma, is an intentional act against an individual which interferes with any sense of empowerment the individual may
have. It can instill within the individual a sense of disconnection from self, others, and the environment.

**Poverty** is a condition in which an individual does not have enough income to meet the basic needs of food, clothing, and shelter.

**Reptilian brain** is the name given to the combination of two parts of the brain—the brainstem and the diencephalon.

**Risk factors** include those issues that contribute to an effect. For example, poverty is a risk factor for neglect, and obesity is a risk factor for high blood pressure.

**Safety**, in this document, refers to both physical and emotional safety and is the first goal in managing trauma work.

**Sensory motor exercises** are exercises intended to provide improved coping skills, assist with self-regulation, and provide healthy outlets for overwhelming emotions.

**Startle reaction** is a symptom of both PTSD and generalized anxiety disorder that occurs when an individual reacts strongly to new and unexpected stimuli in the environment. Bounding out of a chair when a door is slammed is an example of a startle reaction.

**Trauma** refers to overwhelming, uncontrollable experiences that psychologically impact victims by creating in them feelings of helplessness, vulnerability, loss of safety, and loss of control.

**Trauma-Focused Play Therapy** is a therapy that uses toys to externally exhibit the internal representations of an individual’s trauma. It is used to project the
individual’s thoughts and feelings and to process distressing emotional and cognitive constructs from a place of safety.

**Trauma-Focused Cognitive Behavioral Therapy** centers on children’s emotional associations with reminders of their traumas; their distorted thoughts concerning their traumas; and critical thoughts they have about themselves, others, and their world view.

**Trigger** refers to an event, object, or person that sets in motion a series of thoughts that remind a person of some aspect of her or his traumatic past. The person may be unaware of what is “triggering” the memory and could include loud noises, a particular color, a piece of music, an odor, or similar items.

**Vicarious traumatization** refers to the experiences of mental health providers who become overly empathic after listening to accounts of abuse or violence by trauma survivors. Symptoms of vicarious traumatization are similar to those of individuals diagnosed with PTSD and include psychic numbing, hyper-vigilance, difficulty in sleeping, and intrusive thoughts of the trauma reported by the client.
APPENDIX B

Copies of Forms
Code:______________  Date:______________

Gender: Male_______  Female:________  Age:________

Current Position within Fayette County MHMR System:___________________________

How long have you been in this position?____________________

How long have you been with this agency?____________________

Highest Education Degree completed:_________________________
DUQUESNE UNIVERSITY
Dissertation Research
Focus Group Information
New Directions

Code:______________ Date:______________

Gender: Male_______ Female:_________ Age:____________

Current Position with New Directions:______________________

How long have you been in this position?__________________

How long have you been with this agency?__________________

Highest Education Degree completed:______________________
DUQUESNE UNIVERSITY
Dissertation Research
Sign In Sheet for Focus Groups

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APPENDIX C

Copies of Consents and Letter
Dear Parent, Caregiver, or Guardian:

You are invited to attend a Focus Group at New Directions on (To Be Determined) at 1:30 in the afternoon following the general parent meeting. The meeting is for those parents who have a child or adolescent who participated in the trauma group over a six week period. I am interested in your thoughts and reactions to the trauma group. I will lead the focus group and no one else from New Directions will be in this meeting.

I am a doctoral candidate at Duquesne University and I am doing a research project for my dissertation at New Directions, where I also work as a consultant to the staff. I have observed and participated in the trauma groups and my research includes the perceptions of the interested adults who have been a part of these groups in some manner. The research involves asking the staff and parents about their impressions of the groups. An example would be: What is positive about the group? or What could be improved? In addition I hope to learn how staff and parents view the effects of traumatic events on children. I understand the children may never have discussed the group or you may or may not have noticed anything. That is also important information.

Your thoughts and ideas are of value to this research. The group session will be audio-taped and the tape will then be transcribed by the writer, once it is reviewed for accuracy, the audio-tape will be destroyed. The content of the group will be part of the research, however your identity will not be disclosed, each participant will have a code. If you would like to participate, and if you then decide that you do not want to participate you may tell me or inform me at anytime before, during, or after the group meeting.

The day of the focus group you will be given paper work that includes an informed consent that you will need to sign indicating that you are a voluntary participant and a second form concerns the audio-taping.

If you would like to discuss this with me further, please call me at New Directions at 724-735-0764 and leave a message and I will return your call. Your participation will be of great benefit to this research project. Thank you.

Sincerely,

Barb Peck, MSEd
Consultant/ Candidate

Education for the Mind, the Heart, and the Soul
STUDY: What Are the Perceptions of an Interdisciplinary Treatment Team Regarding the Implementation of a Sensory-Motor Group Trauma Curriculum in a Child and Adolescent Partial Hospitalization Program?

I understand that I have been asked to participate in a research study. This study involves the audio-taping either of my individual interview with the researcher, Barb Peck, or my participation in a focus group with the researcher. Neither my name nor any other identifying information will be associated with the audio-tape or the transcript. Only the researcher will be able to listen to the tape.

I understand that the tapes will be transcribed by the researcher and/or the research team and destroyed once the transcriptions are checked for accuracy. Transcripts of my interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither my name nor any other identifying information (such as my voice) will be used in presentations or in written products resulting from the study.

I further understand that immediately following an interview if I am dissatisfied with the content or with the way the interview progressed, I will be given the opportunity to express my concerns and request to have the tape erased.

Please click one of the following options:

Consent to audio-tape interview or focus group

( ) I consent to have my interview or focus group audio-taped.

( ) I do not consent to have my interview/focus group audio-taped.

Consent to transcribe the audio-tape

( ) I consent to have my audio-taped interview/focus group transcribed into written form.

( ) I do not consent to have my audio-taped interview/focus group transcribed into written form.

Consent to use the written transcription

( ) I consent to the use of the written transcription in presentations and written products resulting from this study, provided that neither my name nor other identifying information will be associated with the transcript.

( ) I do not consent to the use of my written transcription in presentation or written products resulting from this study.

I understand that the audio-tapes will be destroyed once they have been transcribed. The transcription will identify me by code only. Only the researcher will have access to the code.

Participant's Signature: _________________________ Date: __________

I hereby agree to abide by the participant’s above instructions.

Researcher's Signature: _________________________ Date: __________

Education for the Mind, the Heart, and the Soul
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

A dissertation research to study the perceptions of an interdisciplinary treatment team regarding the implementation of a sensory-motor trauma curriculum in a child and adolescent partial hospitalization program.

Introduction
I have been asked to take part in a research project as described below. The researcher, Barb Peck, a doctoral candidate at Duquesne University, will explain the project to me in detail. I am free to ask questions. If I have other questions at a later time, Barb Peck will discuss them with me. I understand that this research project fulfills a doctoral requirement. Barb Peck's work telephone number is 724-436-4925-ext-8, her cell phone is 724-344-6814; her email is peckb@duq.edu.

Brief Description of Project
I understand that this research study will explore the perceptions of a multidisciplinary treatment team after implementing a sensory-motor trauma curriculum in a children's partial hospitalization program.

What will Be Done
If I agree to take part in this study, I will talk individually and/or participate with others in a focus group for approximately one to one and a half hours with the researcher, Barb Peck. Barb Peck will ask questions concerning the thoughts, observations, feelings, and suggestions around my impression of the trauma groups and the meaning of the role that I played in that experience.

Risk or Discomforts
If I take part in this research, I understand that it is possible that I may experience some discomfort, sadness, or triggered flashback in talking about trauma issues. However, I will be offered information regarding counseling if I feel I may need some help now or in the future. I understand that I may stop the interview or leave the focus group at any time if I feel that my discomfort becomes overwhelming.

Benefits of the Study
Although there may be no direct benefits for me as a result of taking part in this study, the information I provide may help others understand the impact of trauma on children as well as improve the content of the interventions utilized in the trauma groups.

Compensation
There is no monetary compensation or gift for my participation in this study.

Confidentiality
My part in this research is completely confidential. None of the information will identify me in any way, as all of the information will be coded. Only the researcher will have access to the code that identifies me.

I understand that no information identifying me will be given to anyone. The exception to this confidentiality are the federal and state mandates that reports be made to the authorities when a child is
Voluntary Participation

The decision to participate or not participate in this research study is voluntary on my part. I do not have to participate. If I do decide to take part in this study, I may terminate my participation at anytime. If I wish to terminate my participation in the research study, I simply inform Barb Peck of my decision in person or call her or send an e-mail. Whatever I decide, my participation or lack of participation will in no way affect the services I receive from any agencies from which I might seek help.

Summary of Results

A summary of the results of this research will be supplied to me, at no cost, upon request.

Rights and Complaints

If I am not satisfied with the way this study is conducted or if I believe that I have been injured in any way by participating in this study, I may convey my concerns to Barb Peck (work phone: 724-439-4925 ext 8; cell 724-344-6814; e-mail: barbpeck@duq.edu). I may do so anonymously, if I choose.

I may also write or call Dr. Lisa Lopez Leres (412-396-1871; e-mail: leres@duq.edu) Barb Peck’s dissertation advisor, or a representative of the Institutional Review Board(IRB) at Duquesne University which oversees research involving human subjects. The IRB may be reached at the following address: Institutional Review Board, Office of Research and Sponsored Programs, Duquesne University, Pittsburgh, PA 15282. I may contact the Chair of the Duquesne University Institutional Review Board, Dr Paul Richer, by telephone at 412-396-5533.

I HAVE READ THIS CONSENT FORM. MY QUESTIONS HAVE BEEN ANSWERED. MY SIGNATURE ON THIS FORM INDICATES THAT I UNDERSTAND THE INFORMATION AND I CONSENT TO PARTICIPATE IN THIS STUDY.

Signature of Participant/ Date

Typed/Printed name of Participant

Signature of Researcher/ Date

Barb Peck, ABB, LPC, NCC, MSEd
APPENDIX D

Probe Questions
Semi-Structured Interview Questions for the Teachers and Teacher-aides at New Directions for the Focus Group

1. What is the meaning for you about the inclusion of staff’s input with the trauma curriculum?

2. What do you notice in the classroom after the children and adolescents have been in trauma group?

3. What do you notice on Tuesdays and Thursdays when there is no trauma group?

4. What are your thoughts about incorporating a trauma curriculum in the partial program?

5. What would you like to see changed?

6. Are the children initiating any of the exercises in the classroom? In the hallway? During leisure or recreation time?

7. How do the students respond if you suggest that they try to do one of the exercises?

8. Have you noticed any change in your perceptions or understanding of disruptive behavior in the classroom?
Semi-Structured Interview Questions for the Child and Adolescent Therapists at New Directions for the Focus Group

1. What has been your experience with your involvement in running the trauma groups?

2. What do you notice about the group process?

3. Do you notice a negative response to any of the curriculum protocol?

4. What would you change?

5. What would you keep the same?

6. What changes, if any, do you notice concerning your perception and understanding about the effect of trauma on children and adolescents?

7. What is the curriculum’s most significant feature?

8. What meaning do the groups have for you as you think of your role as co-creator of the curriculum? For the staff?
Semi-Structured Interview Questions for the Fayette County MHMR Focus Group

1. What are your thoughts and perceptions of the implementation of a trauma curriculum at New Directions?

2. Has it changed your view on trauma and children and adolescents? How?

3. What concerns do you have regarding this curriculum?

4. Would you suggest any changes in this sensory format?

5. What about this curriculum is of interest or of value?

6. Does this affect referrals in a positive or negative manner?
Semi-Structured Interview Questions for the Parent Focus Group at New Directions

1. Did your child talk with you about the trauma group?

2. Are you aware of the relaxation exercises that your child learned?

3. Have you observed your child doing any of the exercises?

4. What understanding do you have about the way traumatic situations may have affected your child?

5. What are your thoughts about the trauma group at New Directions?

6. Do you have any ideas or suggestions for improvement that might be made in the group?

7. Was there anything that was positive about the trauma groups?

8. Do you have questions about what might be helpful when children are upset by overwhelming events?
APPENDIX E

Sample Interview Transcription
Barb: Thank you for taking some time today to meet with me. I certainly will make sure you are available for the family games today. I also want to make sure that you realize this meeting will be recorded and then transcribed, and that no one will be identified by name.

Parent J: It's a good thing to check in with us parents and maybe somebody outside of here will pay attention to what these kids are goin' through.

Parent S: That is so true. Few people understand what happens to kids who have problems.

Barb: I just need to check in with the entire group for a minute. I know that was a lot of reading.

[Several group members nodded yes and others said “yes.”]

Barb: Please remember, if you are unhappy with the meeting or upset by something, please see me later in the day or call me here at New Directions. It is important what your thoughts are about trauma or what you consider a traumatic situation to be.

Parent G: Trauma is something that really scares you or really upsets you.

Parent J: I think the very worst trauma is separatin' those kids from their parents, that hurts ‘em real bad, and they don't always understand.

Barb: In the groups, I tried to help the children understand that trauma is something beyond an everyday situation. That a sudden death, or watching family members abuse substances, or serious car accidents, or moving and changing schools . . .

Parent G: He was stayin' with his mother, came to visit us, and she called and said he was too much and didn't want him.

Parent H: I was so glad to have my son with me.

Parent G: I wasn't his mother but he would and still does talk to me. He's been abused. Just tarted talking about it.

Parent H: Somebody beat him. Don't know who.
Parent S: Sometimes, you don’t know what all happened. I have my daughter's sons, as she is seriously ill an’ cannot care for her children. K is six, and he saw medical personnel place a shunt in her arm in the ER. Shortly after he came to live with me, he needed lab work done at the hospital. When the staff went to take blood from his arm, he absolutely flipped out and believed he was getting a shunt. There is no way I possibly knew that would upset him and turn into another traumatic situation for him. Plus, being fearful of new environment and also being separated from his mother.

Parent B: My granddaughter is so afraid she'll be taken from me. She has beautiful porcelain dolls, she never had dolls before, her Mother just didn't bother with her. She needs constant reassurance that this is her home, and if we argue, she almost panics that I won't keep her. Never have I ever mentioned that she would not remain, not even as a threat when she is not listening or pleading relentlessly for something. That fear is always with her.

Parent M: I have three nephews staying with me; two of them have attended here. Even though they have witnessed violence and have been physically abused, the worst thing for them, as bad as it was, was the removal from their home by CYS and police. They were sleeping on mattresses without sheets, and there was little food, but the removal is what they talk about. It is only recently have they been able to say that they do not want to go back to the way things were.

Barb: Did all of you know that your child was participating in trauma group at New Directions?

Parent G: Our son told us after he had been in the group awhile.

Parent H: I think his counselor told us he was going to be in it.

Parent B: Oh, she told me about it and said she was starting to talk more.

Parent N: I did not know he went to them groups but I kinda’ remember gettin’ information about some new group. They told us.

Parent M: I had two kids in the groups. Both of them told me, as did their counselors. It was last year. One never talked about it; the other mentioned it. But this year when he started having problems, it was only after he started talking to you, did I notice him doing the exercises which has helped him manage much better. I saw him use the Pretzel when he was mad at his older bother. He walked into the living room and sat down to do it, and he avoided a nasty fight, which normally happens. It is nice to see. Now two of the three brothers are using them a year later.
Parent S: Oh, yes, I was quite aware he was in the trauma group, and I think that was good for him.

Parent J: I don't know if . . . should be in this group. My brother came to stay with me after our mother went to jail for drug involvement, and it was the end of the group. He has had a hard time, HE IS MAD AND SAD [her emphasis]. In spite of her problems, she loved us, and I know she was involved at this school with my brother.

Barb: I am very glad you are willing to participate today and I want to let you know that, yes, you should be in this group. What do you notice about your brother since he has been with you?

Parent J: Well, he is having a tough time and has angry outbursts. Before he came to me, he was acting out, and the police came to the house, and the State cop told my brother that my mother had every right to smack him on the butt, however, she could not use a weapon or beat him. Since then, his aggressiveness has improved.

Barb: Hi. [A parent who had been involved in an activity just joined the group.] We were just discussing if parents were aware that their child was involved in the trauma groups.

Parent L: [She chuckled.] Oh, yes. [She began to demonstrate the Pretzel and taps.]

[Several parents laughed.]

Parent G: I saw him doing that thing he called the Pretzel. He told me it calmed him better.

Parent B: They showed us that there in a parent meeting.

Parent S: [Laughing.] Is that what that is? We were in church, and I looked over, and my grandson was doing those tap things, and I said to him “What in the world are you doing in church?” and made him stop. I didn't know what that was.

[The group laughed with her.]

Barb: The point of some of the exercises in the group was to help the kids learn others ways to help calm down, and they have been encouraged to use the exercises in the classroom, at recess, on the bus or van, and at home when they are worried or upset. Sometimes, children, when anxious or upset, do not
know what to do to calm themselves. Do any of you have any suggestions about the group itself?

Parent M: [SD 's aunt] I like to read some information that could be helpful to be sent for parents to read about the effects of trauma on children, like a flyer or a flyer that highlights information about the trauma groups.

Parent B: Sometimes, we as fill-in parents don't always get it. Some information would be helpful at least for me.

Parent H: I think a meeting with the parents before the group starts would be good, and you could tell us what's gonna' happen and help us help our kids more.

Parent I: That sound like a good idea to me, and flyer would be a helpful reminder.

Parent L: My son went through a fire, and the babies died. The group and this lady helped my son talk more. He is doin' better. He just got moved to adolescent group, and he's gettin' all 10s on his point card. He needed to move on.

Barb: Maybe the work he did in all areas in the children's section have helped him to do well in this change.

Parent L: That's probably true, but it was time for him to move up.

Barb: For sure, and that is a credit to your son.

Parent L: It took time, but he has done good here at New Directions.

Barb: Do you feel or believe that New Directions is an appropriate setting for the trauma groups?

Parent S: I've gone back to school at Penn State, and I think that someone needs to be getting these kids to talk about what they lived through and given some tools to help with those big feelings that go haywire. Too many times, counselors try to do charts and stickers and don't pay any attention to what is going on behind the behavior. I'm tired of the stickers and charts. Start talking to these kids so they can start to open up. I can't think of a better place for these groups.

Parent M: Ditto on the charts and stickers. The kids have to get that stuff inside out and need to know it is OK to talk about it and be safe at the same time.

Parent H: I think it needs to be here.
Parent G: They helped my son start to talk to us. I think New Directions has done a good job with our son. He couldn't succeed at regular school, he needed help. The medication has helped.

Parent H: Ain't no one gonna' learn if they're upset by what has happened to 'em. Head don't work that way. They gotta talk somewhere where people like the counselors here understand. Them kids know who gets it and who don't. We've talked to some dumb people who don't get it.

Parent B: It has helped my granddaughter hear other kids talk about their problems. The groups belong here.

Parent S: I have never had to deal with CYS.

Parent G: You've never dealt with them? I think that might be a good thing.

Parent I: Yeah, that might be a good thing.

Parent N: That might be a good thing.

Parent L: That's a good thing. [Garbled]

Parent B: Seriously, it's a good thing.

Barb: What would you like to see happen at New Directions?

Parent N: I'd like to watch one of these groups. In a circle with the children with the counselors and tell them how we feel.

Parent G: They wouldn't talk.

Parent G: They [CYS] came to my house. I had no heat, no water, and no food. They come to my house. They're allowed to.

Parent B: They came to my house, too, and my attorney got them.

Parent G: They need to know. They need to know it' hard.

Parent S: That would be a hard group.

Barb: Excuse me, please, but right now our group is having two different and, yet, both important, conversations. In order for us to follow, I would suggest we finish the discussion of both issues, one at a time. There is certainly a lot of
energy for both the idea of a parent-child group as well as CYS concerns. The parent-child group was in response to the question of what you would like to see at New Directions.

Parent S: Well, we may want of not be together 'cause children will say things that will hurt a parent’s heart so bad! See what I'm saying?

Parent G: We know what you’re talking about.

Parent S: Now, that would be a hard group.

Parent S: Now, how can you leave that stuff on the table and go on back home?

Parent N: Maybe we can listen in, like when they are havin' a conversation in a meetin'. OK, I was your parent, and what does your parent do wrong? Without them seein' us.

Barb: You might be able to do a fishbowl group.

Parent J: What is a fishbowl?

Parent N: Is that when you’re in another room?

Barb: No, you all would be in the same room together, but not beside each other.

Parent J: The thing is, with the parent sittin' there, the child isn't goin' to want to say what they really feel.

Parent N: We got feelin’s too, just like the kids do.

Parent G: Right.

Barb: But, it might be interesting for them to hear, if we just narrowed the conversation.

Parent J: Just for a little bit?

Barb: And, another round later.

Parent N: I find myself; honest to goodness sometimes, and they don't know that I do it, I go downstairs and punch a punching bag and get my frustrations out, and it calms me down.
[A child approaches the group.]

Barb: Parents, I don't want to hold you back from being with your kids. I think he want you to play.

Parent L: No, he wants to show . . . . Did you see what he won?

Barb: No.

Parent L: He won a Play Station 2 for perfect attendance, and he wants to play it.

Barb: No wonder! That is great!

Barb: Do you think New Directions is meeting your expectation as far as programming and things that are happening here?

Parent G: Yeah, I do.

Parent H: My son he has come a LONG [his emphasis] way. I do.

Parent B: I do. B has come long way since December.

Parent N: I still have problems at home. He’s doing good in school, and I think I know why. Two other bosses.

[The tape recorder stopped at this point. The tape was flipped and the recording began again.]

Barb: Tell me about the water.

Parent N: We have to carry water in this trailer, and we have no commode now because the township said you have to have a tank inside the ground, and if that tank remains there, it's a $500 a day fine, and we have to move, and that's what we're doing. And Welfare and Community Action said they would try to help us. More than likely, I'm homeless right now. I still live in the trailer.

Barb: How do think that affects the boys?

Parent N: It affects them real bad, but they still want to stay, because they still have animals, and I don't like it. I don't like it. I’d rather have a commode and water. I'm tired of carryin' water in, especially when I got other things to do. I got to clean house, take care of responsibilities, and that puts a lot of pressure on them too. And, now, I have to move because I'm with somebody who's
goin' back to his wife, and he's more like a kid. He has an adult's body but a mind like a kid. Too many bosses. I want to be the parent. Let me be the parent. And they said they was goin' to get adopted, and I know that they heard it from somebody's mouth. My kids are not gettin' taken away from me. I've not been bad to 'em.

Parent J: Why would they be taken away?

Parent N: Because when they run away, well, people said they was taken off me and all that. Where would they hear adoption at? They went up to the guy who I just broke up with, his wife's house. She's more of a mom than me. I don't know what it is but they're angry. That's why. The one guy I see got very upset with me, 'cause I told him he had to clean up his mess 'cause I just had cleaned it. He says 'I'm tryin' to watch the movie, so shut up. I'll clean up the mess later.' He got up off the couch. I pointed my finger, he got very mad. I just pointed my finger. I did not touch him. He pushed me and shoved me. My cousin, I have to go and see a therapist at Chestnut Ridge, she said that's why I have to go right now, see a therapist. I don't like that. I should not have to see a therapist.

[At this point the remaining parents went back to the Fun Day festivities with their children.]