

## CHAPTER FIVE

### *Overview*

### *Structured Sensory Intervention for Traumatized Children, Adolescents & Parents (SITCAP)*

#### **Eight to Ten Sessions**

*Structured Sensory Intervention for Traumatized Children, Adolescents and Parents* is an eight to ten session intervention. The attention of pre-school aged children varies from fifteen to twenty-five minutes. It therefore takes ten sessions to cover the major themes of trauma for that age group. Children, adolescents and adult/parent intervention involves eight structured sessions which address the major themes of trauma in a sequential manner. Activities vary to some degree with different age levels, but the primary intervention processes and focus on major trauma sensations and themes are used with all age levels.

Participants in SITCAP may not need all eight sessions as levels of severity and reactions will vary. Some participants may need additional intervention. SITCAP lends itself to identifying those reactions (themes) that may need additional attention. Additional intervention, if needed, can therefore be very focused and specific to the client's needs. Overall reactions, for example, may see a reduction but safety remains a primary worry. Additional intervention would then concentrate on safety issues. Some individuals may also see major reductions in all three DSM-IV subcategories, yet need "first aid" following additional exposure or when entering different developmental periods.

The goals of SITCAP are:

- Stabilization (return to previous level of functioning or prevention of further dysfunction).
- Identification of PTSD reactions;
- The opportunity to revisit the trauma in the supportive, reassuring presence of an adult (professional) who understands the value of providing this opportunity.
- An opportunity to find relief from trauma-induced terror, worry, hurt, anger, revenge, accountability, powerlessness, and the need for safety;
- An opportunity to re-establish a positive “connectiveness” to the adult world;
- Normalization of current and future reactions;
- Support of the heroic efforts to become a survivor rather than a victim of their experience;
- When appropriate, assistance for parents in resolving those reactions triggered by their child’s traumatization;
- Replacement of the traumatic sensory experience with positive sensory experiences;
- Identification of additional needs and recognition of the role parents can take to help meet those needs;
- The provisioning of parents with ways to respond to their traumatized child’s reactions.

### **The Structure**

The structure in which these strategies are initiated is critical to maintaining a sense of safety while actively involving the child, adolescent or parent in the healing process. The first session educates the participant as to the structure of the program, how it works, what can be expected, the choices they have in the process, the differences between grief and trauma, and the normalization of their reactions. After the second session the victim/survivor knows how to respond, and what to expect. He gets comfortable with the predictability of the process. The structure is also a benefit for the trauma intervener. It provides direction; where to go next, what to do, what to say. It also affords the intervener the same sense of safety and

control. Most importantly it keeps the intervener in the role of witness versus clinician. Victims desperately want to, and are capable of, sharing the details of their experience - to make us a witness to that experience. To be a witness, we must be involved in the child's telling of the story by being curious about all that happened. To engage this "witness" role, the intervener must be very concrete and literal in response to all the elements of the story, its details and the visual representations provided by the child, adolescent or parent. If the intervener attempts to make sense of the child's emotional status by analyzing "why", he will not be able to experience the trauma as the child is experiencing it. He will not "know it" as the child knows it, and the child, adolescent or parent will not experience the intervener as a witness, as someone who is with him in his experience. He will sense he is alone and shut down to protect himself.

SITCAP's structure also places boundaries on the intervener as well as the victim. Part of becoming a witness is seeing how the victim now views himself and the world around him following the trauma. To see what the victim sees is to understand and know what will be helpful. Because trauma is a sensory experience the memory is often stored symbolically. Images - how one looks at himself and the world around him - defines what that trauma was like. Even adults rarely have words to adequately describe what their experience was like, but they can show us. Presenting that visual representation must be done in a structured fashion. Boundaries provide the structure, which promotes a "sensory" safety. Boundaries in drawing involve the use of only 8 1/2" x 11" paper and fine point, color pencils or felt markers. Drawing activities are structured versus unstructured. They direct themselves to helping the victim describe how specific sensations or themes of trauma like fear, revenge, hurt are now impacting his life.

### **Focus On Themes, Not Behavior**

SITCAP focuses on ten major sensations or themes: fear, terror, worry, hurt, anger, revenge, accountability, safety, power and throughout the process shifting from victim thinking to survivor thinking. This process, therefore, does not direct itself to attempting to treat behavior but rather the sensations (themes) that fuel and drive the behavior. One seven-year old boy, for example, at age three saw his father kill his mother. He was later kidnapped by his father who had posted bail.

For the next six months he was held captive by his father. He was left alone for long periods of time and witnessed his father beat several women. There was a four-year period from the time this boy was rescued to the time SITCAP was initiated. During that time two primary behaviors resulting from his trauma surfaced. The first was that he slept on the floor every night and the second was he would seldom leave his grandmother's side. He would even follow her into the bathroom at times making it difficult for her to have any privacy without a struggle.

Sleeping on the floor was a way of being in a state of readiness for any danger that might come his way. Following his grandmother into the bathroom was rooted in the sensation of fear. His behaviors were helping, at a sensory level, to create the sensation of safety. SITCAP did not directly address this boy's behavior, but his fears and worries. By helping him re-experience the sensation of safety, his levels of fear and worry were reduced and the behavior changed. Following the restoration of the sense of safety, he began to cognitively alter his responses.

In another example, Robert, an eleven-year old boy was facing his second suspension from school for fighting. One year earlier his older sister was brutally raped and murdered by a serial killer. He was not a witness to the killing, but was certainly traumatized by his sister's murder and all the exposure from the media that followed. Fighting had not previously been a problem. His mother reported that it was totally unlike her son.

Attempts at peer mediation and conflict resolution, which frequently focus on behavior and seek resolution through cognitive approaches simply failed. At a sensory level, this youngster was terrified. His "fighting response" was an attempt, at a sensory level, to not feel afraid. It was a way for him to overpower his fear; to communicate to others and to himself, "No one is going to do to me what was done to my sister." SITCAP helped him to "recapture", at a sensory level, a sense of power and safety that helped diminish the fighting response. Help the victim with the sensations of trauma and behavior will change accordingly.

### **Details**

Part of telling the story is asking questions to elicit details. Obtaining details is

another very important component of the SITCAP process. For the victim, details can provide a sense of control as well as a sense of relief. For the intervener, details can point the way to helping the client find relief.

When asked where he felt the hurt the most, Robert, the eleven year old boy whose sister was brutally murdered one year earlier, said, “All over my body when I was told. It was like I was in shock and then I got a big headache.” He continued to experience the headaches when he thought of his sister. While pursuing this with him he told the story of how, on the same night his sister was discovered missing, his friend was in a car accident. His friend’s head went through the windshield, and he died. Given the high profile of the murder, no one ever dealt with this second traumatization that seemed minimal compared to the murder. Only by providing Robert the opportunity to tell the entire story and all the details of what happened at the time of the incident did this second trauma reveal itself as a source of some of the headaches he was experiencing. He in essence had two stories to tell. All too often, it is the events following the primary trauma that trigger trauma reactions.

The structure of SITCAP keeps the intervener and child focused on details as a way of being able to later “see” the experience differently, to cognitively reframe it in a way that is now manageable. Details also can provide information that helps to make sense out of what happened and may still be happening with the child.

### **Education**

Structuring statements at intake clearly identify how the process works, what will be expected and what outcome can be anticipated. The time devoted to “structuring” the SITCAP process helps to reduce anxiety. It also helps victims to make an informed consent. All too often the counselors simply move directly into treatment without addressing the implications for the client. The client is not prepared to really confirm, “Yes, this is what I want.” SITCAP uses specific resource materials for this educational component to ensure the child has some sense of what he is about to experience as well as learn.

SITCAP also structures itself to teach the victim the difference between grief and trauma. If a loved one was undergoing surgery and the doctor told you he would meet with you in the surgical waiting room when the operation was

completed at 3 p.m., and if at 3:15 p.m. the doctor had not yet shown up, you would panic. You would begin to think the worst. What you need more than anything else to calm your anxiety is information. A trauma victim's needs are no different. Information about trauma lessens anxiety. Normalizing trauma reactions helps to make sense out of what happened while supporting the fact that what is being experienced is quite normal. This helps to decrease anxiety.

### **Grief and Trauma**

Not everyone who experiences grief will experience trauma, but everyone who experience a trauma will also experience grief. However, trauma is so overpowering that it often “buries” grief reactions. Once a victim is helped to find relief from the terror of their trauma and re-experiences a renewed sense of power, buried grief reactions often emerge. In reality, one is often dealing with grief and trauma simultaneously. The focus of intervention therefore must address both. SITCAP structures it's activities to respond to grief and trauma.

### **Type of Incidents**

SITCAP addresses Type I and Type II incidents (Terr 1991). Type I refers to a single trauma-inducing incident. Type II trauma refers to a single incident, like sexual abuse, repeated over a chronic period of time, or multiple traumas (different incidents). By addressing the major themes of trauma SITCAP is beneficial for both Type I and Type II incidents. It addresses those incidents that are assaultive and violent, such as murder, physical/sexual abuse, domestic violence, armed assault and suicide. It also addresses incidents of a non-assaultive origin, such as terminal illness, critical injury, natural disasters, car fatalities, house fires, drowning, divorce or separation from parents.

### **Age, Gender, Ethnicity**

It is important to remember that trauma has very few boundaries when it comes to culture, ethnicity, gender or age. Whatever an adult can experience in trauma, a

child can also experience. Whatever a child can experience in trauma, an adult can also experience.

A twenty-seven year old woman's brother was shot and killed just outside her home. As she tells her story, she describes hearing the gunshot and immediately knowing it was her brother who was shot. He was a random victim in this case. There was no gang or drug history. When she ran outside her fear was confirmed. She said that as she approached his body she wanted to touch him, but she knew if she "touched him he would die." She could not touch him.

This woman's response is an example of "magical thinking". Magical thinking is a reaction generally assigned to young children who believe it was something they thought, said, or wished for that was the cause of death of a family member or friend. Whatever a child can experience, however, an adult in trauma can experience. A forty-two year old nurse's teenage son was shot and killed outside her home. Telling her story, she talks about looking at that spot twenty-four hours a day. She goes on to say that at times she's cooking something on the stove and forgets she's cooking. The close physical proximity to the trauma, among other elements, has kept her in the hyperarousal state. Forgetting she is cooking is a short-term memory loss associated with the mid-brain arousal response that is experienced by children as well as adults. It manifests itself in traumatized children who seem "not to be listening" because they cannot remember what they were asked to do just five minutes earlier.

### **SITCAP Qualities**

SITCAP intervention adjusts activities for developmental differences, but its focus on major sensations or themes versus behavior allows it to help reduce symptoms across age levels. Its primary intervention processes of exposure, trauma narrative and cognitive reframing, remain the processes for pre-school aged children, elementary aged children, adolescents and adults.

Structured Sensory Intervention is unique in several ways.

- Intervention can be initiated for either violent or non-violent trauma incidents of the type detailed earlier.
- Intervention addresses children of pre-school age, children 6 - 12 years old,

adolescents and adults.

- Activity worksheets accompany each session and are designed to facilitate focus on the major themes of trauma.
- The interventions are so structured, trauma-focused and client-oriented that clinicians who follow the format are afforded little opportunity to inappropriately respond.
- Field-tested in schools as well as agency settings, the model and its interventions meet the many limitations placed on school counselors, social workers and clinicians.
- Rather than address symptoms, the model focuses on the themes of trauma -- fear, terror, worry, hurt, anger, revenge, accountability, safety, power and being a survivor versus a victim.
- Given the reality that parental involvement is frequently minimal, the model encourages a minimum of two sessions with parents. These are specifically structured and designed to obtain necessary information and support, and to provide the opportunity to make the parent a witness to the ways the trauma has impacted the child so as to increase the likelihood that parental response to the child is the most supportive.
- The parent component also addresses those parents whose child's trauma has triggered reactions from their own person history or parents who themselves suffer a trauma not involving their child, but creating problems for them in their role as a parent.
- Exposure is accomplished by drawing activities. Developing the trauma narrative is accomplished through asking trauma-specific questions, and cognitive reframing is structured to speak to the major sensations of trauma.
- Resource materials for the child/parent ensure that they receive the information (education) they need about the differences between grief and trauma as well as the course the intervention will take. These are also included in a structured booklet format to ensure that the interveners are, in fact, covering the important issues.
- The model is outcome driven. An assessment tool is available to identify current reactions and their severity levels. It provides a baseline to compare initial levels of severity to final outcomes. It is clinically based, so it serves

as a diagnostic tool to support third party insurance requirements for approved treatment and if needed, continuation beyond the short-term period.

- The components of SITCAP are also designed to assist school/community's response to critical incidents. In school environments, school shootings, car fatalities, and sudden death of staff dictate a specific series of interventions from the first day through several weeks. The SITCAP model provides these interventions. (Detailed in Chapter Nine, Debriefing.)

### Drawing

Although discussed in earlier chapters, the importance of drawing in accomplishing these goals bears reviewing as drawing itself is a major component of SITCAP.

- Drawing is a psychomotor activity. Because trauma is a sensory experience, not a cognitive experience, intervention is necessary to trigger those sensory memories. Drawing triggers those sensory memories when it is trauma focused. It provides a safe vehicle to communicate what children, even adults, often have few words to describe.
- Drawing engages the child/adult in the active involvement with their own healing. It takes them from a passive to an active, directed, controlled externalization of that trauma and its reactions.
- Drawing provides a symbolic representation of the trauma experience in a format that is now external, concrete, and therefore manageable. The paper acts as a container of that trauma.
- Drawing provides a visual focus on details that encourage the client via trauma-specific questions, to tell his story, to give it a language so it can be reordered in a way that is manageable.
- Drawing also provides for the diminishing of reactivity (anxiety) to trauma memories through repeated visual reexposure in a medium that is perceived and felt by the client to be safe.

## Trauma-Specific Questions

In addition to drawing, trauma-specific questions are used to help in the telling of the story and detailing with reactions experienced.

Questions are directed to trauma themes and focus on trauma sensations, and are also directed to the details of the trauma incident itself. Following are some examples:

- “What do you remember seeing or hearing?” relates to the overall sensory imploding of detailed components of the trauma.
- “Do you sometimes think about what happened even when you don’t want to?” deals with intrusive thoughts.
- “Do certain sounds, sights, smells, etc, sometimes suddenly remind you of what happened?” refers to startle reactions.
- “What would you like to see happen to the person (or thing) that caused this to happen?” deals with anger and revenge.
- “Do you sometimes think it should have been you instead?” is an accountability (survivor guilt) question.

Throughout the process, questions are specific to the theme being addressed. Their concreteness keeps the child focused on the specific theme, encourages the narrative (story) to be told for each theme, and encourages the attention to detail. Details, as discussed earlier, are critical to helping establish a sense of control and provide the intervener with information needed to help the child find relief.

Multiple questions are asked because the specific trauma reference may be worry, not anger or revenge. The child’s trauma reference may be about the hurt experienced at a sensory level not the physical level. It may be accountability for some, fear for others. SITCAP encourages the systematic presentation of all questions and attention to all themes to give the victim the opportunity to make us a witness to his specific trauma reference.

### Example

It was New Year’s Eve. A high school senior was ushering at a movie complex where several movies ran concurrently. He was slated to graduate in the spring and had been accepted into the police academy. Also a football player, he was physi-

cally quite strong and stood over six feet tall. Several kids in the movie he was assigned to were causing trouble. He attempted to get control but was unable to do so. He sought out the manager for help, but the manager had a full house and told him he would just have to handle it on his own. The situation did not change. In this complex, movies were scheduled so several let out at the same time. There was a “common” area that the theatres opened into, so everyone was moving into this area simultaneously. The youngster took his post across the common area outside the doors of the movie he was responsible to monitor. When the youths he had trouble with came out of the movie and into the common area they spotted him, rushed him, knocked him down and began beating on him. They broke his nose and several ribs. About a month later his parish priest, who was trying to help this youngster, called for assistance. The boy was skipping school and not attending the youth activities at church, which was not at all like him.

“What was the worst part for you?” was one of the trauma-specific questions that helped to encourage this youngster’s telling of the story and focusing on specific details. When this case was presented in trainings and participants were asked to anticipate what the “worst part” must have been, their numerous responses rarely identified what the worst part was for this teenager. Responses ranged from the anger he felt at the manager for leaving him on his own, the embarrassment and shame that he couldn’t help himself and the pain he felt during the beating. The point is, what we often as observers consider to be the worst part is not necessarily experienced by the victim. Only by giving the victim the opportunity to make us a witness can we truly know his experience as he knows it.

The teen’s response was as follows:

“I can see it as if it is happening all over again. I’m on the ground and they’re kicking me. As they are kicking me I can see between their legs. (this kind of detail is unique to trauma in which events seem to happen almost in slow motion so that such details emerge.) As I’m looking between their legs, I see all these people standing around and no one is helping me.”

At that moment in time, he experienced complete abandonment, betrayed by the adults in his world. Without appropriate intervention this could have easily triggered very self-defeating, even destructive responses. He had already begun to

isolate himself, was missing school and was putting his future in jeopardy. If he had gone much longer without help, it would not have been unusual for him to start carrying a weapon, join a gang, or even actively seek out the kids who beat him with the intent of getting revenge. Being unable to trust the adult world was the worst part of his experience and one that often leads to destructive behavior and identifying with the aggressor.

By asking this one trauma-specific question, the specialist was able to help this teen work through the abandonment he experienced; a focus that likely would have otherwise gone untreated.

### **Cognitive Reframing**

Cognitive reframing is scripted in SITCAP to insure that the victim is provided a “survivors” way of making sense of the trauma experience. The goal is to help move the victim from “victim thinking” to “survivor thinking” which leads to empowerment, choice, active involvement in their own healing process and a renewed sense of safety and hope.

Activities also assist in supporting the reframing of the experience. The high school senior, in our earlier example, who was beaten on New Year’s Eve and had lost trust in the adult world, withdrew. By having him draw what his fears looked like and later giving them a name, he realized he was responding as a victim to his own fear that, if the police academy found out, they would never allow him to start his training. This was irrational, but not from a “victim’s” viewpoint. A sense of shame and hopelessness also emerged as his view of self now was one of not being able to take care of himself. He reasoned, “If I can’t take care of myself how can I take care of others?” When asked why standard operating procedure of police was to always work with a partner, he was able to refocus on the reality that alone, even in the midst of bystanders, protection and help was not always given. Working in pairs, he realized, dealt with the reality that even the police could find themselves suddenly overwhelmed. At a cognitive level, he was then able to reframe that what happened to him was not his fault and that as a police officer he would be doing for others what others could not do for him - help. In this sense, cognitive framing allowed him to reorder his experience in a way that gave his future new meaning.

## Parent Involvement

A good deal of research has concluded that parents are critical to their child's ability to recover from trauma. Pynoos and Nader (1988) and Vogel and Verberg (1993) cited parents as the single most important support for school age children following a disaster. Byers (1996) reported that studies following World War II showed that the level of upset displayed by the adult in the child's life, not the war itself, was the single most important factor in predicting the emotional well being and recovery of the child. We see the same relationship today.

An unstable parent creates an unstable child. A traumatized adult will find it difficult to help their traumatized child. Schwarz (1991) and many others have found that adults (parents), more frequently than children, experienced the greatest distress when presented with a trauma. van der Kolk (1996) wrote "most children are amazingly resilient as long as they have caregivers that are emotionally available."

When a child has been traumatized, his parents also experience extreme distress and often are unable to adequately respond to their traumatized children without appropriate intervention.

Learning about trauma helps parents who themselves have been traumatized, especially when their experience is brought back to life (triggered) by their child's traumatic experience. Education is an essential, necessary component to help the parent become aware of how her own unresolved fears block her ability to allow her child to openly tell his story. The child needs a parent who is not terrified and emotionally overwhelmed. Parents with their own history often discover that their child's experience threatens to bring all the terror of their own experience back to life. Unknowingly, they reject their child's cry for help, or minimize the child's terror in hopes of calming the child.

Given the reality that parent involvement in intervention can be minimal, two sessions with parents can still support significant reduction of trauma reactions in their children. This is especially the case if those sessions are structured and focused on helping the parent become "a witness" to their child's experience as well.

Parents generally underestimate the impact trauma has on their children. This

is partially due to not understanding how trauma is different than grief and how it manifests itself in children. Therefore, parents need to be educated. Furthermore, until a parent can experience what the child has experienced, it is difficult for her to understand and accept recommendations as to how she needs to respond differently to her child. Deblinger, Lippman, & Steer (1996) conducted a very structured intervention with parents and children who were sexually abused. Exposure, developing the trauma narrative, and cognitive restructuring were the primary interventions. Of most importance was the finding related to parental involvement; the greatest reductions were seen in those cases where parents participated in the intervention. Children seen without the parent did not realize the same gains.

However, the intervention must be structured. The purpose of the first session with the parent is to obtain factual information about the trauma and to identify changes in the child's behavior, mood, emotions, relationships, and performance since the trauma. The parent also needs to learn what trauma is and the ways she can be helpful during the intervention process. This information should be in written form as it must be seen as well as heard.

The assumption is that the professional leading the intervention will have been trained in the differences between grief and trauma and can be very concrete and specific in the description of trauma to parents. Appropriate trauma-specific intervention cannot be provided by the professional who cannot identify the five major differences between grief and trauma, provide explicit examples for each of the trauma-specific reactions as classified in the DSM-IVTR, nor review the ten major themes of trauma with the parent. This is the type of information learned and practiced in training at the Institute.

The second session with the parent comes only after the child has had the several sessions needed to construct the trauma narrative and can provide visual representations (drawings) of how that experience has impacted him. This would take place at the seventh session when using the SITCAP model. In that seventh session, the child will use his drawings to tell his story. The parent should be allowed to be a witness to this experience just as the professional has been over the sessions leading up to this meeting with the parent. This is a very critical and pivotal session. It is an opportunity to reconnect the child's trust in his parent; to relate to the parent as someone who understands (as the professional does). It is an

opportunity for the parent to become a witness, to appreciate the need to respond differently to her child, affording her child the sense of safety and protection so desperately needed to become a survivor.

In the example of the seven-year old boy who slept on the floor for fear of falling asleep in bed and followed his grandmother into the bathroom, he had never been given the opportunity to make his grandmother a witness to his experience. She knew her grandson had been terribly traumatized, yet at a sensory level did not really “know”. Her standard response to him following her into the bathroom and sleeping on the floor was, “You’re a big boy now. Seven year olds do not follow their grandma into the bathroom.” This was a predictable response, as was her frustration with him at times.

Others had told her to be patient, that it would take time for him to get over this. She didn’t understand this because she was not a witness to how the murder had impacted her grandson. No one had involved this youngster in trauma-specific drawings or the pursuit of trauma themes. He did not really have a way to tell his mother until he was involved in SITCAP. It was only when grandmother became a witness that she really “knew” and could thereafter respond differently.

When asked to draw a picture of what happened to his mother (**Plate 1**) he drew his father with a gun, the bullet in the middle of the air, mom in the direction of the oncoming bullet. He drew himself standing next to mom.

When asked to tell what happened, he replied, “My dad, he be’s mean to my mom. She was happy because she was going to move out of the house to my grandma’s. She went out to the car and when she came back to get me, because she forgot me, then my dad shot her. The police then came and got my dad.”

Grandmother had never heard this story. It doesn’t matter whether it’s real - it is what is driving his behavior. In three years of therapy no one had ever asked him to draw a picture of what happened. No one ever asked him to draw a picture of his mother dead, nor asked the kinds of trauma questions asked in this interview. Within a few short minutes of the beginning of an hour-long telling of the story, grandmother quickly came to know his fear, his terror of being left alone. If we had attempted through the traditional approach of suggesting to her ways to respond differently, they would have been difficult for her to accept. Experiencing his trauma at a sensory level, seeing it as he saw it, helped her to know his need

for safety and reassurance as well as know how to provide that reassurance on those days he was feeling vulnerable and powerless.

### **Levels of Parent Involvement**

There are three possible levels of parent involvement with trauma. At the first level a parent's child has been traumatized, and the parent needs assistance to understand what trauma is, how it is different from grief and the ways she can best help her child recover. To accomplish this, the parent needs to learn about trauma, the process of intervention, and then be a witness to her child's trauma through the child's telling of the story with drawings in the same way he made the intervener a witness. This can be accomplished in two sessions: at intake and then again after the child has completed SITCAP intervention which could be completed in as few as two sessions or as many as eight.

The second level deals with the parent whose child has been traumatized, and that trauma triggers memories and reactions of the parent's own past personal experience with trauma. The triggering of these trauma-related reactions frequently prevents the parent from appropriately attending to the child's specific trauma needs. The child's fears trigger the parent's fears. Predictably, parents often shut down to protect themselves; to get control of their own fears. These parents need the opportunity to address their trauma issues with the goal of helping them "be there" for their child. This can often be accomplished in two sessions (in addition to the regular sessions directed at helping the child). In some cases the parent's trauma may necessitate intervention of a level three nature.

At level three the parent has suffered a trauma, but not the child. The parent's trauma is likely to get in the way of functioning as a parent to the child and also disrupt the relationship with the spouse. The same major themes addressed with children and adolescents are addressed with the adult. Drawing remains a primary activity along with telling the story and cognitive reframing.

An additional focus with level three parents is secondary wounding. Secondary wounding refers to the responses from others following the trauma, especially those in the position of helpers. "At least you're alive." "You're young, you'll get over it." "It really couldn't have happened that way. You're over reacting." "If only

you would have \_\_\_\_.” These responses do wound. Often victims report that the wounding suffered after the trauma is worse and harder to get past than the actual trauma. Secondary wounding can occur with reactions of denial and disbelief, discounting and minimizing, blaming, treating one as defective, and through system victimization. Structured intervention for parents addresses these issues and provides the education and treatment to help parents help themselves and help their children. The parent intervention process is detailed in Chapter Eight.

### **SITCAP and Schools**

Schools have special needs following trauma-inducing, critical incidents. The school environment itself is quite unique. Interventions provided in the community are not always easily adaptable to the uniqueness of the school environment and its population. Varied developmental levels and special populations necessitate interventions comprehensive enough to meet these varied needs. The administration of a school also presents unique functions that interventions must take into consideration.

The SITCAP model provides a comprehensive series of trauma debriefing interventions specifically for schools, students, staff and administration. Trauma debriefing intervention includes the following interventions. Debriefing for the adolescent and adult population, defusing for younger children, operational debriefing for all staff, crisis team debriefing for school crisis team members, and the classroom presentation are the varied interventions needed and structured by SITCAP.

The stages of each of these models are detailed in *Trauma Debriefing Handbook for Schools and Agencies* (Steele, 2008). The Handbook provides step-by-step movement through each process and provides the support material considered a necessary component for helping schools heal from their trauma. These interventions are designed to accelerate the healing process and prevent future PTSD reactions. However, for some, especially the most exposed, additional intervention is often needed. The transition into the children and adolescent programs within the SITCAP model provide the interventions that debriefing cannot provide. See Chapter Eight Debriefing Trauma Specific Interventions for Schools and Agencies.

### **Detailed Intervention Practices**

The SITCAP model provides very structured, sensory focused interventions for pre-school children three to six years, children six to twelve years and adolescents thirteen to eighteen years. This model incorporates the notion that major sensations following trauma inducement are common to each age group. Fear, worry, hurt, anger, revenge, accountability, safety, power and survivor versus victim thinking and behavior are experienced at a sensory level. When these reactions are incomplete or “frozen” in the trauma state, the “completion” of these responses to trauma must be discharged at a sensory level in order to restore balance to the child (Levine, 1996).

The intervention activities used to restore balance to the traumatized child are, as detailed earlier, based upon exposure through drawing, trauma narrative through trauma-specific questions directed to the major sensations experienced and specific questions to elicit the details of the story developed by the child and cognitive reframing. Although the activities vary to appropriately fit the developmental levels of the children, the process and focus remains the same for each age group. Practitioners will be able to initiate and integrate this process into practice but caution is still urged and training recommended as any process is best experienced before using. As safety is of major concern in treating traumatized children, such caution is believed, by the authors, to be a professional responsibility.

The detailing of each individual session for the three different groups would be far too extensive for this text. However, by providing examples of how the different sensations are approached with each age group, an understanding will be established for the process and its value, which are documented by research and field-testing.

There are several areas that do not change regardless of the age of the child. As stated, the trauma sensations addressed are the same. These sensations are also referred to as the themes of trauma. A specific sensation can run through the child’s reaction to his experience and appear as a “theme”. The requested number of visits and focus of parental involvement in intervention is the same. Each program uses activity worksheets that are titled according to the theme being addressed. This is What Happened, is one activity worksheet, for example, used

with each age group. The focus on developing survivor thinking and behavior is common also to each age group. The programs are short term, running an average of eight sessions. The pre-school program has ten sessions simply because the concentration span of pre-school children is shorter, as are the sessions for the preschool children. Programs have been field-tested and researched in school settings as well as agency settings to ensure they work within the parameters and needs of these two settings.

