At times, traumatic incidents occur that involve a large number of people who could benefit from debriefing in small groups of eight to ten participants, but situations only allow for meeting in larger numbers of twenty to thirty plus participants at one time. Obviously, the debriefing process must be adjusted to accommodate the larger numbers.

Trauma specialists may only be provided with one opportunity to meet with this large group. It is our belief that you cannot properly debrief more than eight people in a group setting, as it takes close to two hours for all participants to have the opportunity to tell their stories. Also, we do not encourage debriefing to go past two hours because of the risk of participants becoming overwhelmed and too exhausted to protect their emotional “self.” So, what can trauma specialists do?

The National Institute has learned over the past eleven years that some intervention is better than no intervention for trauma victims. We have, in the past, often been asked to debrief groups of twenty or more professionals. We will provide two examples and discuss how they were approached. One group (Group A) consisted of teachers, social workers, counselors, and administrators in a school setting combined with mental health professionals called in to assist school personnel. The other group (Group B) was made up of law enforcement personnel. Both situations involved a shooting death; the one of a student inside the school, the other of an officer in the community.

Most vs. Least Exposed

When first called, we were informed that there were approximately twenty to thirty participants who wanted us to meet with them, including those who were at the scene during the traumatic incident and therefore, most exposed at the visual and the sensory level. Attempts to persuade (educate) the administrators to allow us to debrief no more than eight participants in multiple sessions, conducted simultaneously, failed. Efforts to initially meet with the most exposed separately, apart from the others also failed. This necessitated the “rescripting” of the debriefing process, especially the opening statements.

Structuring Opening Statements

In the larger format, it is very important to immediately readjust expectations of the group as to what can be accomplished in a large group. It is also important to say that additional help may be needed because the group size prohibits you from addressing all the questions used in a formal debriefing.

After introducing yourselves to the group, briefly mention that experience has taught you that debriefing can be helpful and can accelerate the healing process. Follow this brief opening with the following structuring statements:

“Debriefing is usually conducted with no more that eight persons in a group to give each per-

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son an opportunity to tell their complete story, their thoughts, the ways the situation has impacted them. This is not possible with your group so we have selected just a few questions of the many we normally ask. Because this will be an abbreviated debriefing, some of you may want an additional session to give yourselves the opportunity to get relief from some of the issues we may not be able to address today.

“There are, as you know, those of you here today who were on the scene when _______ happened or there immediately after, and those who were there much later and therefore, not exposed to the same elements. Those of you who were there please feel free not to answer our questions. It is perfectly okay, especially in a large group like this. Not everyone will have a lot to say or much to say today, but listening to your colleagues and peers will be helpful to you.”

Order

Group A (teachers, social workers, counselors, and administrators along with mental health professionals) was directed to raise their hands if they wished to respond to the question posed above. A final check was made before going on to the next question to see if anyone wished to add anything. A visual scan should be made from one end of the semi circle to the other end in order to make sure that all participants have acknowledged the questions. In Group B, the law enforcement group, those on the scene were asked to respond first followed by other participants in a sequential order that was then continued. Both methods worked well. Ms. Trimble, one of the debriefers of the law enforcement group, was familiar with the team members, but the only member not in law enforcement. Only three of the twenty some participants in Group A were familiar to Mr. Steele. Confidentiality and other ground rules were established at this point.

Gaining Credibility

Ms. Trimble was introduced by an officer in Group B who was on the debriefing team. Because other team members had not previously conducted a debriefing, they asked Ms. Trimble to start the process. Knowing that law enforcement and other “first responders” often feel out of control and helpless, especially when one of their own has died, she took a few minutes to address how these reactions could leave them not wanting to talk. She also acknowledged that they might be cautious about what they did say, because this process was new to them and, because she herself was not in law enforcement. She then indicated that the process is generally very helpful, and that they would benefit in some way. Following this she thanked them for allowing her “in” to help.

Mr. Steele initiated similar comments with Group A and especially directed his attention to the concern that school personnel might have with responding in a group with non-school personnel. The same applied to non-school personnel. He invited participants to call him anytime should there be things they would like to talk or ask about following the debriefing.

Debriefers of both groups found that participants were appreciative of their honesty, sensitivity to these issues, and directness. Many reported afterward that they needed to hear these comments from the debriefers in order to feel comfortable with participating.

Questions

Both group debriefings took place approximately one week after the incident, after the victim’s funeral. Debriefers of both groups began by first asking who the participants were and their relationship to the victim. This gave each participant the opportunity to respond regardless of the nature of their exposure. “Where were you when it happened, or when you first found out, and what did you do?” was the next question. This led to participants identifying different details related to varied aspects of the events that followed that day and that week. The one question not asked in both groups was, “What do you remember seeing and hearing?” There was concern that if those who were witnesses went into too much detail as to what they saw (the sensory), that it might make it more difficult for the non-witnesses to process their existing reactions.

The next question asked was, “What one thought stands out the most for you since this happened?” In both cases participants talked about their own reactions to different parts of all that happened. The issues of “should haves” or “I could haves” at the funeral and, even having to be in the group, were some of the issues that emerged. These questions, in both situations, set the stage for
those who were initially reluctant to participate (reported by participants before leaving). It made it far easier for them to respond later.

When asked, “What was the worst part?” both group participants identified events following the incident such as the funeral, the media issues, community members, parent reactions; specific factors reminding them of what happened and difficulties they experienced in trying to help the most exposed. Personal reactions as well as system issues were discussed.

When asked, “Of all the thoughts or reactions you had, what one reaction or thought surprised you the most?” participants detailed more personal reactions, e.g. disbelief, denial, not being able to think clearly, being numb, confused, moving in slow motion, freezing, and not able to perform simple tasks such as dialing frequently called phone numbers. In the law enforcement group (Group B), those who apprehended the killer of the officer some seven hours later talked about being surprised at their being able to properly treat the killer. In Group A, several talked about how difficult it was for them to get past the disbelief that this young child had actually shot and killed a classmate, even though they were looking at the girl’s body on the floor. This question allowed some of the participants who had said little to identify their personal reactions.

In Group A, the next question of “Where are you experiencing this the most in your body?” further helped to build a “shared connectedness” among participants, as each could easily relate their physical response to all that happened; many had similar reactions. Those unable to identify earlier reactions could relate to the physical reactions they were experiencing, which helped develop that “connectedness” with other members. The result was the same in the law enforcement group.

Time

Group A was completed in two hours while Group B ran an hour and a half. After a break, officers at the scene and the dispatchers returned for additional debriefing of the details and personal reactions which they did not wish to talk about in the larger group. This was very beneficial for those most exposed individuals. The most exposed members in the education group did not want to return. The offer was again made one week later with no reply. This was unfortunate, as we have found that, among the most exposed, many do need the smaller, more personal and thorough debriefing.

Summary

Two different groups using the same approach shared similar reactions, but also unique reactions. The law enforcement group was more a “family” than the education group which was comprised of different school district team members, county team members, and school personnel. Those most exposed in the law enforcement group were more open to additional debriefing; this was not the case with the education group members. The law enforcement group was one operating system, whereas, the education group were multiple systems which may have been more effectively helped if allowed to debrief separately. Despite the issues that prohibited a formal debriefing, the majority of members from both groups did express that the process was helpful.

Situations will continue that will not allow a formal debriefing to be conducted; yet some education and processing for survivors is still very helpful. Even though each situation will be unique structure remains important. The fact that debriefers went into each of these situations with predetermined questions and a structured opening was calming for the participants as well as the debriefers.

Ms. Trimble wrote after her debriefing, “It would have been a disaster had we not altered the ‘debriefing’ format and predetermined the questions we were going to ask. In order to minimize their anxiety and enhance my credibility with these officers, I was introduced by an officer who had worked with me in previous debriefings and acknowledged that my brother, a State Trooper, was one of the team members. I felt that it was critical, in my opening statements, to assure the participants that this was a structured and controlled procedure. The positive feedback we received following the session reinforced the vital importance of the debriefing.

“I continue to be amazed at how this process helps the participants relax and ‘give in’ to the grief and trauma. As they tell their stories, you can see the body language change as the process takes over. The healing has begun. What a rewarding feeling.” ◆
Commentary

Crisis Response to Attack on America

Bobbi Stoll, MFT, CTS, CGP, ATR-BC

Directors Note: This commentary provides the reader with a “sense” of the multitude of factors that emerge in the few days following such a tragedy. The shock, denial and confusion that one can be exposed to as an intervenor are intensified and prolonged by the terror induced by the incident itself and exposure to the incident via national media coverage.

It was September 11, 2001 5:48 AM Pacific time when Los Angeles-bound American Airlines flight #11 struck the North Tower of the World Trade Center in New York and at 6:03 AM Pacific time Los Angeles-bound United Airlines flight #175 hit the South Tower. 42 minutes later a second American Airlines flight #77 crashed into the Pentagon in Washington, D.C. About 9:00 AM Pacific time I received the first call from the Red Cross chapter in Los Angeles enlist Dis-case Mental Health (DMH) workers to report to the Los Angeles airport (LAX) to meet the families and friends expecting to meet passengers on one of the three hijacked flights destined for Los Angeles.

By 10:00 AM the American Airlines Family & Friends Reception Center had been established at LAX Terminal 4. Within 1 hour, LAX was closed and the Reception Center moved to the Airport Marriott Hotel nearby. I was on-site at the Marriott by 1:30 PM. United Airlines had a similar Reception Center at the Sheraton Gateway, and the Emergency Operations Center (EOC) for both sites was at the Airport Hilton Hotel. All three hotels were within a few blocks of each other on Century Blvd., the main artery to the airport.

The FBI, first on the scene, coordinated with the American Red Cross the protocol to be followed. They urged families to come to the Center and were expecting them to arrive over the next 24 hours. Local families would arrive first; others were driving from Phoenix, Tucson, San Diego, and other parts of California. The FBI wanted to interview every arriving family and rented hotel rooms and suites to insure their comfort during the questioning and provide a place to spend the night if needed. The Reception Center, staffed by 4 of many FBI agents, one Red Cross coordinator and 5 DMH workers, consisted of two large adjoining lounges outfitted with staff and public telephones and a bountiful 24 hour buffet that was restocked as needed between luncheon and dinner buffets. A television in one of the lounges was for the staff and out of public view. The media -newsmen, local and national TV, CNN, magazine reporters, and others - representing many languages, were everywhere pressing the police and hotel security guards at the barriers and accosting any FBI or Red Cross worker coming or going into or out of the area. The Red Cross Public Information Officer (PIO), whose job is to respond to media questions, was overwhelmed with persistent questioning and needed more relief than was immediately available.

After the FBI interviews, families were escorted to the Reception Center where food, drinks, and mental health support were available. Some were crying, others showed signs of having been crying, most were in shock, dazed, numb, and paralyzed, and hoping their loved one would be among any survivors.

With unanswered questions on the death toll, about what happened on those hijacked planes and...
why, and, as yet, no casualty list, no one knew who to blame, how to comprehend, or if they could continue hoping their loved one would be found alive. Their denial was thus supported and they seemed to exist in suspended animation. All were encouraged to seek help when and as needed. I felt as helpless and ineffective as most family members. It was premature to grieve, there was no way to understand such tragic events, DMH workers, staff, and others in similar disbelief were fixed in front of the television watching the constant replays of fire and smoke issuing from the north tower and the inferno when UAL #175 struck the south tower.

The horror seemed to increase exponentially, when, some time later, UAL #93’s crash in Shanksville, PA was related to the other three hijackings, President Bush’s return to Washington from Florida was via a circuitous route, and all flights were grounded.

Returning from 8 hours at the Reception Center, I found six messages from Employee Assistance Programs and HMO’s requesting debriefings for brokerages, banks, law firms, various entertainment-related companies and agents. I spent the next three days of the week doing corporate debriefings and was unavailable for Red Cross assignment although the Center remains open and calls have gone out to other Southland counties for DMH replacements.

Corporate calls for grief groups and critical incident debriefings have continued as offices and companies have experienced the impact of the East coast tragedies. Banking, brokerages, law firms, insurance companies, computer and entertainment industries are bi-coastal and many Los Angeles offices are mourning the loss of co-workers, an entire branch office, or their home office. Offices in high rise buildings in Beverly Hills and Century City, while experiencing no direct loss, believe Los Angeles is an intended target and feel threatened "because it’s not over yet.” Employee absence has been high, their productivity impaired, and symptoms of post-traumatic stress are becoming evident. Many individual employees who moved to the Los Angeles office from a New York branch or home office in the World Trade Center lost friends, former co-workers, and, in some cases, family members. One former New Yorker who was in the WTC during the 1993 bombing re-experienced that traumatic threat to her life and renewed her grief for friends who died. Business is itself at a standstill and jobs feel threatened. This brings associated guilt to employees who feel unentitled to worry about their jobs while others died or are suffering greater losses.

As I write this on September 15 - just 4 days after the Attack on America- it is apparent that, like the death toll, the emotional toll on America is yet to be tallied. In the past 3 days, many more calls have been received from companies and individuals experiencing difficulty coping with the aftermath of such a disaster. Each new announcement - of delayed flights, calling up 50,000 reserves, heightened airport security, the FBI investigations uncovering new suspects in our midst, and the Day of Mourning and candlelight vigil have seemed ominous to already terrorized Angelenos. With no predictable end to the cleanup operation in New York or Washington, the emotional recovery will continue for a very long time. ◆
Parental suicide is one of the most devastating experiences a child can experience. The following paper compares and contrasts 4 studies pertaining to the effects of parental suicide on the surviving children, draws clinical implications for treatment of suicide-bereaved children, and discusses where future research is needed. The studies agree that following parental suicide children experience high levels of anxiety, depression, and posttraumatic stress. In some studies, these children undergo some form of psychosocial maladjustment, as evidenced by their reactions to the parent’s suicide. The studies also find that some surviving parents are likely to experience psychiatric symptomatology after the suicide. There is a consensus regarding treatment, stressing early identification of suicide-bereaved children and early intervention.

Each year, approximately 60,000 children experience the suicide of a relative (Pfeffer et al., 1997). Approximately 7,000-12,000 children experience parental suicide in the United States alone (Cerel et al., 1999). Because suicides are often underreported, the exact numbers may be significantly higher (Forbes et al., 2000). In addition, these statistics do not include the number of children who are exposed to their parents’ suicide attempts (Heikes, 1997).

According to Forbes et al. (2000), children are capable of understanding the meaning of suicide, and this understanding is not related to IQ or other cognitive measures. They must be able to make sense of their parent's decision to end his or her own life and the grief and stigma associated with the act of suicide (Cerel et al., 1999). Generally, survivors of suicide experience more preoccupation with the deceased and with suicide attempts compared to survivors who lose their parents due to circumstances other than suicide (terminal illness or accidental death) (Cerel et al., 1999). When mourning the loss of a family member, Suicide-Bereaved Children (SBC) experience anxiety, anger, and shame (Cerel et al., 2000; Thompson et al., 1998). In the first 25 months after a parental suicide, children are also more likely to exhibit increased behavior problems and overall psychiatric symptomatology, such as depression, anxiety, interpersonal problems and posttraumatic stress disorders—psychological factors that make the child particularly vulnerable to suicide as an adult (Cerel et al., 1999, 2000; Forbes et al., 2000; Pfeffer et al., 1997).

This paper will examine research on children’s adjustment to parental suicide. The four studies to be analyzed cover adjustment to school, family life, and psychopathology. Treatment implications will be addressed, as well as directions for future research.

**Conceptual Framework**

Previous treatment plans for SBC have focused on providing therapy only to these survivors. A multidimensional perspective, involving the family and larger social systems on which the child depends upon, is a more effective approach. This perspective is based on the idea that the individual is inseparable from the

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pattern of interactions and relationships within the family (Halgin & Krauss-Whitbourne, 1997). Until the family can provide the child a sense of safety and stability, the child may be afraid that he or she or other family members may also die (Heikes, 1997).

Parental suicide does not only affect the child, but the spouse and the deceased’s family as well. Like child survivors, adults are likely to experience high levels of psychiatric symptoms, such as anxiety and depression (Pfeffer et al., 1997). Family members often say nothing because they are afraid they are not capable of finding the right words. In addition, the social stigma of suicide may cause the adult survivors to withdraw from other family members and the community, instilling a sense of disconnectedness from these individuals and the deceased (Cerel et al., 2000; Heikes, 1997; Pfeffer et al., 1997). This is evident in isolation, loss of social support, feelings of ineffectiveness, lack of self-actualization, and psychological maladjustment experienced by adult survivors, resulting in emotional unavailability and a lack of focus on the child. This further exacerbates the psychosocial adjustment of suicide-bereaved children (Heikes, 1997).

Meanwhile, adult survivors must recognize that the child’s mourning process takes time. The act of parental suicide seriously damages the child’s ability to rely on their caretakers, since the parent did not possess self-restraint to prevent the suicide. Because of this, a child’s grieving process may entail the following phases: disorganization, working through emotions, and reorganization while striving for mastery and integration of the trauma and loss (Heikes, 1997).

**Review of Relevant Studies**

**Study #1**

Pfeffer et al. (1997) examined the relationship between the psychiatric symptoms of the suicide-bereaved parents and the psychiatric symptoms and social adjustment of their children. In this study, 16 families with 22 children were gathered through referrals. The racial and ethnic distribution of the families included 12 white and 4 African-American and Hispanic families.

The researchers used five semi-structured interviews and questionnaires with the children. The Spectrum of Suicidal and Assaultive Behaviors Scales, which assesses the severity of the children’s recent suicidal/assaultive thoughts or attempts; the Social Adjustment Inventory for Children and Adolescents (SAICA), which looks at the current social adjustment in school, spare-time activities, peer relations, and home life; the Childhood Post-traumatic Stress Reaction Index (CPTSD), which identifies the severity of post-traumatic stress symptoms; the Revised Children’s Manifest Anxiety Scale (CMAS), which examines anxiety two weeks post-suicide; and finally, the Children’s Depression Inventory (CDI), which determines the severity of depressive symptoms.

Questionnaires were also administered to gather parents’ reports of their children’s and their own psychosocial adjustment: 1) The Coddington Social Readjustment Rating Questionnaire for Children and Adolescents measures the degree of change in children’s accustomed pattern of life resulting from life events; 2) The Child Behavior Checklist (CBCL) allows parents to rate their children’s social competencies and behavior problems; 3) the Beck Depression Inventory (BDI) examines the severity of symptoms of depression two weeks following the suicide; and 4) the Symptom Checklist-90-Checklist Revised (SCR-90-R) assesses the psychiatric symptoms immediately after or within 6 months of a spouse’s suicide. (Additional information for some of these measures in this study and the three following are summarized in Table 5).

The results for SBC, non-SBC, and their surviving parents are summarized in Table 1 (see tables at end of article). Based on this information, the researchers concluded that psychosocial maladjustment was linked with environmental issues like psychiatric disturbance in the parent/caretaker and recent stress-inducing life events (Pfeffer et al., 1997).

This study was limited by the small sample size, which meant most of the analyses were exploratory. That is, data from the study was ana-
analyzed using family units in order to avoid problems inherent in the codependent effects of siblings. In addition, regression models were used in order to identify predictors of children's psychiatric symptoms and level of social adjustment, which reflected an overlap of predictor variables. Finally, due to the high rate of posttraumatic stress symptoms among the low number of non-white families, the data required additional exploration in a larger sample of child survivors of suicide.

The study depended on the recruitment of the participants, who were found by referral, creating the possibility of an inflated percentage of children and adolescents with emotional disturbances. The cross-sectional data in the study also did not allow one to infer whether or not the suicide resulted in the incidence of emotional disturbances in these children, nor did it address whether or not this existed prior to the parental suicide.

**Study #2**

Cerel et al. (1999) examined grief reactions, psychiatric symptoms manifested, and psychosocial functioning following parental death in both SBC and non-SBC. 26 SBC from 15 families and approximately 332 non-suicide-bereaved participants were studied. No differences existed in terms of gender, age, and race (Cerel et al., 1999). The first measure administered was the Grief-Interview Child and Parent forms, comprised of open-ended and semi-structured questions about the child’s grief experience (sadness, anger, jealousy, anxiety, guilt, shame, relief, acceptance, and posttraumatic stress disorder symptoms). To measure emotional disturbance, four measures were administered: the BAMO scale, the Diagnostic Interview for Depression in Children and Adolescents Revised (DIDCA-R), the Child Depression Inventory (CDI), and the Children's Depression Rating Scale-Revised (CDRS-R).

Results for SBC, non-SBC, and their surviving parents are summarized in Table 2. The researchers found that the effect of a death by suicide was more problematic for SBC than their non-suicide-bereaved counterparts. They concluded the loss of the parent to suicide might be linked to more long-term adjustment problems. A similarity discovered between the two groups was discovered: they shared similar grief reactions, which demonstrated the normalization of the grief process for suicide-bereaved families (Cerel et al., 1999).

Like the 1997 study by Pfeffer et al., a relatively small sample size was used, which prevented generalizing results and within-group comparisons. There was also a question as to whether or not the sample this study utilized represented the population of SBC. The researchers attempted to recruit ethnically diverse participants, but their sample was actually mostly white. This limited generalizing the findings to non-white populations.

**Study #3**

A follow-up study a year later examined psychopathology in the dead and surviving parents, stability in the family before entering the study, family functioning before and after the death, and changes in social support (Cerel et al., 2000). The same SBC and non-SBC families were compared. For this study, the researchers placed these families in one of three possible categories: functional families, those with no preexisting psychopathology or conflict; chaotic families, those who had psychopathology or turmoil prior to the suicide; and encapsulated pathology families, where the deceased possessed psychological conflict, but the families did not. Like the previous study, these families were compared with 332 non-suicide-bereaved participants (Cerel et al., 2000).

For the adult participants, the Hamilton Rating Scale for Depression (Ham-D), a severity rating scale used to measure depressive symptoms in adults, was administered. The Psychiatric Diagnostic Interview (PDI) was also used to measure 17 psychiatric diagnoses in adults; the Family History Research Diagnostic Criteria (FH-RDC) interview to assess symptoms of emotional disturbance in immediate relatives of the child; and the Home Environment
Interview-Abbreviated Version-Child and Parent forms to access information about the quality and quantity of familial and non-familial interactions prior to the suicide. The children in the study were also given the FH-RDC, and the DIDCA-R to find out information about DSM-III-R symptoms and psychosocial stressors in children (Cerel et al., 2000).

The study found that those who committed suicide were more likely to suffer from major depressive disorder, bipolar disorder, and alcohol and drug abuse than deceased parents in the non-suicide group. Although this confirmed the family systems perspectives of suicide, there was no clinical documentation. The researchers inferred that neither set of parents were less effective parents following the death (Cerel et al., 2000). Additional information can be found in Table 3.

In terms of family stability, the suicide-bereaved families were less functional than the non-suicide-bereaved families. They were more likely to be involved in marital separation and to have one family member receiving mental health treatment. SBC were less likely than non-SBC to experience psychosocial stressors following the death, which researchers attributed to disruptions in the suicide-bereaved families stemming from the deceased’s lifestyle. Following the death, the deceased and his or her lifestyle was no longer an issue for these families (Cerel et al., 2000).

Meanwhile, surviving parents stated that their children had been less likely to engage in activities with the parent who committed suicide than the children of parents who did not commit suicide. The researchers indicated that this parent was not capable of having a quality relationship with the child due to his or her illness or divorce, which researchers believed served as a buffer for the children by exposing them less to the parent’s problems, leading to a better relationship with the surviving parent. There was no difference between the two groups, however, in the amount of activities engaged by the surviving parent and child (Cerel et al., 2000).

The researchers noted that SBC were less likely to report that they engaged in fewer activities, unlike surviving parents. One explanation for this might be that the children were probably “glossing over” negative aspects of their parents in order to have good memories of them after they died. It is also possible that the surviving parent might be either unaware of or unwilling to acknowledge any sort of positive relationship, especially if they themselves had a stormy relationship with the deceased. Suicide-bereaved families also indicated that they participated in fewer activities as a family unit than the non-suicide-bereaved families. Differences emerged before the suicide for suicide-bereaved families, and between 6 and 13 months after death for non-suicide-bereaved families (Cerel et al., 2000).

Over half the children in the study said they talked to at least one person about their feelings within a month of the parent’s death. This led the researchers to conclude that there were no differences in social support for these two groups. There were also no differences in the amount of religious observance, which the researchers explained by the fact that suicide has become less stigmatized during the last two decades. However, the researchers acknowledged there were more subtle ways that the stigma affected the survivors (Cerel et al., 2000).

The researchers found that despite having a psychologically competent parent, SBC experienced some form of emotional disturbance. It is possible that the coping mechanism of the surviving parent to maintain his or her mental welfare was not as protective for the children. It is also possible that the children have a genetic predisposition for certain types of psychopathology, inherited from the deceased parent. Additionally, SBC’s psychiatric symptoms may be due to their exposure to more stressful events during the course of their lives than non-SBC. Finally, the SBC could have had a conflicted relationship with the dead parent (Cerel et al., 2000).

Like the two studies discussed earlier, a small sample of suicide-bereaved families was studied, limiting the study’s scope and the ability to do within-group comparisons. The manner in which some of the measures were collected
could be considered less than sophisticated. For instance, the analysis of family activities was limited to a scale that examined five broad areas. Measures more subtle in nature might have been better equipped to capture interactional differences between suicide-bereaved families and non-suicide-bereaved families. In addition, the primary means of data collection was conducted through secondary self-report.

**Study #4**

Thompson et al. (1998) claimed that prior research yielded mixed results when it came to gender differences in manifesting their grief over a parent’s death. Their study not only attempted to look at the clinical distress associated with losing a parent (from suicide, homicide, or natural causes), but also to examine the possible correlation between self-reports between the children and their parents regarding both emotional and behavioral functioning (Thompson et al., 1998).

The sample in this study was composed of 80 children, ranging in age from 9 to 16 years, and was compared with 45 non-bereaved children. The bereaved children were recruited through the Grady Health System (an inner-city hospital, serving low socioeconomic and minority populations) medical records, records of the Victim Witness Assistance Program (an agency that serves homicide victim's families), and Hospice Atlanta (an agency that serves terminally-ill individuals), obituaries, Infectious Disease Program documents (an HIV clinic affiliated with Grady Health System), and self-referral or other sources (Thompson et al., 1998). Children were excluded from the study if they demonstrated psychotic symptoms on the Schedule for Affective Disorders for School-Aged Children (KIDDIE-SADS). The researchers used the CBCL and the Youth Self Report (YSR) in order to assess whether or not the children’s behaviors reflected psychological difficulties and behavioral problems, as reported by the guardians on the CBCL and the children on the YSR.

There were no between-group differences present. Guardians of the children, especially those of SBC, tended to be older, less educated, unemployed, or had lower status jobs than non-bereaved children. Most of the guardians of SBC were mothers, followed by grandmothers, aunts, fathers, sisters, and grandfathers (Thompson et al., 1998). Bereaved children were grouped together and their scores were compared. In addition, demographic variables of the surviving parents and guardians were examined (Thompson et al., 1998).

There were no significant differences statistically on within-group analyses for the bereaved children on the CBCL and the YSR. In addition, age did not appear to be a main or interactive effect on child distress. Meanwhile, gender of the suicide-bereaved child exhibited main effects (the effects of the gender variable averaging over all levels of other variables) on externalizing scores (Thompson et al., 1998). In addition, the researchers found that the race of the child did not change with other variable levels. However, this became a factor when it came to the externalizing scores by the parents’ reports of their children’s behavior. Non-minority bereaved children scored significantly higher than their non-bereaved controls, while minority children only scored slightly higher. The researchers were cautious, because there were only 4 non-minority respondents in the control group (Thompson et al., 1998). Additional information on the results of this study can be located in Table 4.

The researchers concluded that losing a parent to death, especially by suicide, was related to a higher occurrence of guardian-reported psychological symptomatology and behavioral problems. In addition, externalizing scale scores on the CBCL interacted with race, especially between minority and non-minority children. While there were minimal differences between minority bereaved and non-bereaved children, there were significant differences between non-minority bereaved and non-bereaved children on the externalizing scale. It was also discovered that girls scored higher than boys on externalizing on the CBCL, contrasting with previous research (Thompson et al., 1998).

There were some limitations to this study. First of all, it was retrospective. Limitations in
the study also stemmed from the correlation present in the data. For instance, it was impossible to state that parental death led to a rise in emotional and behavioral difficulties. There was also a heavy reliance on self-reports to measure emotional distress. Additionally, there was a sampling bias because minority children were not referred clinically. Since the study contained no information regarding the children who did not participate in the study, it became difficult to make assumptions about the sampling bias present. Therefore, generalizability of the findings is limited. Finally, there was limited extant data regarding the similarities and differences in child- and parent-reported psychological symptoms after a suicide.

Comparison of Studies

Among the four studies, there were similarities. All concluded that SBC were at increased risk for developing some form of psychological disorder: anxiety, depression, externalizing and internalizing their grief (Cerel et al., 1999, 2000; Pfeffer et al., 1997; Thompson et al., 1998). In addition, these children face social adversities, as seen in peer relations, school behavior, and self-esteem (Cerel et al., 1999, 2000; Pfeffer et al., 1997; Thompson et al., 1998). The Pfeffer et al. (1997) and the Thompson et al. (1998) studies found that the surviving parents experienced high levels of anxiety and depression after the suicide. The two studies by Cerel et al. (1999, 2000) and the one by Pfeffer et al. (1997) discovered suicide-bereaved families underwent more chaos and turmoil than their non-suicide bereaved counterparts, which affected the children’s subsequent psychosocial development in the aftermath of the parent’s suicide. In addition, both Cerel et al. (1999, 2000) studies also found that the act of suicide was less stigmatized now by society than in the past. This allowed the survivors to grieve openly and to partake in traditional death rituals.

All four studies worked with small samples since the populations were hard to identify and contact. This made generalizing the results to other populations quite difficult (with the exception of the 1998 study by Thompson et al., most of the studies were unable to recruit ethnic minorities). Between and within group comparisons were also difficult to conduct because of limited sample sizes.

For all the similarities the studies shared, there were some differences. While in most studies, boys externalized their grief, girls scored higher on externalizing scales in the Thompson et al.'s 1998 study. While two studies (Pfeffer et al. 1997; Thompson et al. 1998) agreed that surviving parents were more likely to develop symptoms of a psychological disorder, Cerel et al. (2000) found that the living parents were no more likely to develop mental health problems than non-suicide bereaved parents.

Most of these studies used interviews (semi-structured and structured) and questionnaires to assess emotional and behavioral disturbances in children associated with parental suicide (Cerel et al., 1999, 2000; Pfeffer et al., 1997). However, Thompson et al. (1998) was the only study that used self-reports. While the study by Cerel et al. (2000) consulted with teachers regarding SBC's psychosocial adjustment to school after the parent’s suicide, the other studies did not include teachers.

Clinical Implications

The four studies reviewed in this paper have suggestions for clinicians regarding the treatment for children (and in some cases, the surviving parents) who have experienced the death of parental suicide. Some researchers suggested early identification and intervention (Cerel et al., 1999; Pfeffer et al., 1997), while others stated that clinicians should be aware of the surviving parent's possible psychological distress, which might exacerbate the child's symptoms (Cerel et al., 2000). All stressed that the clinician recognize and address the significant levels of psychological disturbance of non-SBC and experimental controls, brought on by a suicide of a parent (Cerel et al., 1999, 2000; Pfeffer et al., 1997; Thompson et al., 1998). The following section will detail the clinical implica-
The 1999 study by Cerel et al. found that SBC were at increased risk for mental illness and suicide. Manifestation started in childhood through behavioral problems and general psychiatric symptoms before death and 25 months after the suicide. Early intervention, therefore, was imperative for these children (Cerel et al., 1999). The follow-up study suggested that programs be available in order to assist surviving parents with their children's reactions to parental suicide since SBC experienced more psychological distress than their surviving parents (Cerel et al., 2000). Meanwhile, Thompson et al. (1998) recommended that clinicians should be aware of the possibility for significant distress, particularly with younger children, who have been proven to be quite vulnerable to bereavement-related stress (Thompson et al., 1998).

Pfeffer et al. (1997) suggested that clinicians should aim to lessen SBC's mood and anxiety problems, accomplished by direct treatment and modification of the environment. The latter would decrease parental psychopathology and the likelihood of severe, stressful life events. Also recommended was the early identification of SBC, so that preventive intervention could be implemented prior to impaired intervention could be implemented prior to impaired social functioning or clinically significant symptoms appearing, as well as examining the surviving parent's psychosocial needs (Pfeffer et al., 1997).

The studies do not detail what types of intervention clinicians should provide. Using the recommendations from the four studies, the family systems approach, and the case study by Heikes (1997), possible programs to treat suicide-bereaved families will be outlined here.

**Recommendations for Treatment**

For effective treatment of SBC, therapeutic programs should be implemented in school settings. Ideally, the suicide-bereaved child would be assigned a therapist, who would work individually with the child and provide services to the family. The team leader of such a program could be a counselor or a social worker. The rest of the team would be comprised of other professionals including the child's classroom teacher, other classroom paraprofessionals, and a psychiatrist (Heikes, 1997). These individuals would consult with the team leader as to the course of treatment for the child and the family. Therapy should be conducted as soon as possible in order to provide the early intervention needed to lessen the devastating effects of a parent's suicide.

In individual therapy, the team leader would emphasize the child's level of understanding and integration of the trauma and the importance of mourning the loss of the parent (Heikes, 1997). As part of family treatment, the team could relay the information from the sessions with the child to help the other survivors understand the child's mourning process (Ethically, the counselor would have to make sure the child was willing to have the information discussed individually before sharing it in family counseling). The team would facilitate conversations with the caretakers about how to help the child cope with the traumatic event of a parent's suicide. By sharing information with the adults in the child's life, an opportunity to become prepared to talk about these types of issues is provided and gives both an implicit and explicit message that it is alright to discuss a previously taboo topic (Heikes, 1997).

In addition, it would be important for the team leader to share observations of the child's behavior, the nature of the child's grief and trauma, and the sense of uncertainty the child may have in daily living in therapy with the surviving family. This would help the adults in the child's life become more patient and empathetic and to accept the child's behavior (Heikes, 1997).

Therapy should also strengthen the familial connections because a symptomatic member often reflects conflicts within the family system. While the team assists the family in restructuring, an emphasis should be on keeping them as connected as possible. A family member's suicide is a stressful event that may fragment the unit due to beliefs regarding the death (who is to blame, what should have been done to prevent it, etc.).

Support groups may also be an important therapeutic component for both SBC and their...
caretakers, and children’s support groups may be specialized by gender. Because girls tend to internalize their feelings regarding the death of a parent (Halgin & Krauss-Whitbourne, 1997), the support group should focus on helping them verbalize their feelings and sort out their thoughts and emotions about the suicide. Boys, who often externalize grief (Halgin & Krauss-Whitbourne, 1997), should be involved in a group that would help them channel their emotions into more constructive behaviors. A support group of other adult survivors of suicide would help reduce the level of psychopathology in caretakers, and would aid them in helping children adjust.

**Future Areas of Research**

While the four studies covered new and important areas in the realm of SBC, some aspects were not addressed. For instance, the long-term impact of parental suicide on children is not known. Follow-up of these children as they become adults must be conducted in order to assess the impact of parental suicide during childhood on adult development, and with their families, who use programs to deal with their children’s emotional reactions. The latter would gauge how the surviving parents and children cope over time.

Another research question not addressed in these studies deals with the increased understanding of practitioners regarding the mechanisms that promote the incidence of suicidal behavior. Potential studies of child survivors of suicide could be conducted in order to determine the risk they face of committing suicide themselves. While past literature has included parental suicide as a factor, it has not addressed when the suicide took place in the participant’s life.

As noted earlier, Thompson et al. (1998) discovered that non-minority SBC are more vulnerable to psychological distress. Future research could entail replicating the finding since the original study included a small pool of participants, which was subjected to some form of sampling bias. Another set of related research questions should search for possible answers for the relative vulnerability of non-minority SBC.

The last prospective research question concerns the duration of childhood grieving following parental suicide. Specifically, regarding the existence of certain stages in the grieving process for SBC and surviving parents, and if so, what they are. Only Cerel et al.’s (1999) study indicates a similar grieving process for SBC and non-SBC.

**Conclusions**

Suicide-Bereaved Children have a higher risk of developing some form of psychopathology, whether it is anxiety, depression, posttraumatic stress disorder, or a combination of the three. Parental suicide is a unique and devastating experience for children and their surviving caretaker. The clinician should be aware of the effects on the child’s psychosocial adjustment of his or her environment at home and at school. Because the grief process is gradual and complex, great care should be taken in providing mental health treatment for these individuals.

**References**


Table 1
Summary of major findings from Pfeffer et al. (1997) study

- SBC experienced anxiety and environmental distress before and after parental suicide
- SBC experienced higher rates of internalizing symptoms, such as anxiety, depression, posttraumatic stress, and significant social maladjustment
- Possible sources for social maladjustment included psychiatric symptoms present in the surviving parent/caretaker and stressful events before and after the suicide
- Surviving parents of SBC experienced significantly higher levels of psychiatric symptoms and were at greater risk for psychiatric disturbance
- Surviving parents of SBC scored higher than normal controls on the majority of items on the SCR-90-R, but lower when compared to psychiatric outpatients
- Scores on the BDI were moderate, which suggested the presence of mild depression

Table 2
Summary of major findings from Cerel et al. (1999) study

- SBC experienced anxiety immediately after the death, then anger
- SBC were less likely than non-SBC to experience relief or accepting of it by 1-2 years after the death
- SBC were vulnerable to global behavioral problems and higher rates of anxiety
- Both SBC and non-SBC reported one or more grief emotions following the death
- Both SBC and non-SBC similar grief reactions
- Both SBC and non-SBC demonstrated equal amounts of symptomatology, including posttraumatic stress and depressive symptoms, suicidal ideation, and problems with behavior at school, peer relations, and self-esteem
- The domains of psychiatric symptoms for surviving parents of SBC were significantly associated with children’s psychiatric symptoms or social maladjustment

Table 3
Summary of major findings from Ceredi et al. (2000) study

- SBC less likely than non-SBC to experience psychosocial stressors following the death
- More than half of the children in the study said they talked to at least one person about their feelings within a month of the parent’s death
- Both surviving parents of SBC and non-SBC provided similar reports of psychopathology on both the FH-RDC and the PDI before and after the death
- Both surviving parents of SBC and non-SBC also reported suffering some impairment following the death
- Neither set of parents appeared to be less effective parents following the death

Table 4
Summary of major findings from Thompson et al. (1998) study

- SBC were more likely than non-SBC to score in the clinical range for both externalizing and internalizing behaviors
- There were significant differences between bereaved children and non-bereaved children on the clinical and borderline clinical YSR broadband scores
- Non-minority bereaved children scored significantly higher than their non-bereaved controls on the clinical and borderline clinical YSR broadband scores
- Minority children only scored slightly higher on the clinical and borderline clinical YSR broadband scores
- Girls scored higher on externalizing scales
- Age did not appear to be a main or interactive effect on child distress
- Surviving parents of SBC experienced high levels of anxiety and depression after the suicide

Table 5
Summarization of Some Instruments Used for SBC and non-SBC in Pfeffer et al. (1997), Cerel et al. (1999, 2000), and Thompson et al. (1998) studies

BAMO scale (Cerel et al. 1999): Designed specifically for this study, this is a continuous scale that evaluates symptoms of behavioral (attention-deficit/hyperactivity disorder, conduct disorder, and oppositional defiant disorder), anxiety (obsessive-compulsive disorder), mood (major depression), and other types of disorders (elimination disorders and somatization disorder). For each diagnosis, a child scores between 0 and 1. A score of 0 reflects no symptoms endorsed for that diagnosis, whereas a score of 1 indicates the child endorsed all possible symptoms for that diagnosis. To obtain a score for each diagnosis, the number of symptoms endorsed is divided by the number of possible symptoms. These are given half weight in the final summation, where scores can range from 0 to 18.

Child Behavior Checklist (CBCL) (Achenbach, 1991): This checklist was designed for children ages 4-18, to record in a standardized format children’s competencies and problems as reported by their parents or guardians. The 20 competence items obtain parents’ reports of the amount and quality of their child’s participation in sports, hobbies, games, activities, jobs and chores, and friendships; how well the child gets along with others and plays and works alone; and school functioning. Each of the specific problem items and two open-ended problem items are scored on a 3-step response scale.
Child Depression Inventory (CDI)/Kovacs (1992): This is a self-report, symptom-oriented scale designed for all school-aged children and adolescents (ages 7-17 years). It has 27 items, each of which consists of three choices. The child or adolescent is instructed to select one sentence for each item that best describes him or her for the past two weeks. The factors contained on the CDI are negative mood, interpersonal problems.

Children’s Depression Rating Scale-Revised (CDRS-R)/Poznanski et al. (1984): This scale assesses current severity of depressive symptoms in children and adolescents. It was modeled after the Hamilton Rating Scale for Depression for adults. The scale correlates with global ratings for depression. In addition, observations can be used to observe overt behaviors such as diminished social and motor activity that may suggest depression.

Childhood Post-traumatic Stress Reaction Index (CPTSRI)/Pynoos et al. (1987): This is a 20-item self-report scale designed to assess post-traumatic stress reactions of children of 6-16 years following exposure to a broad range of traumatic events. Items are rated on a 0-4 scale. Scores were classified as mild PTSD reaction (total score of 12-24), moderate (25-39), severe (40-59), and very severe (above 60).

Coddington Social Readjustment Rating Questionnaire for Children and Adolescents/ Coddington (1972): The items are relevant to children, covering topics such as “divorce of parents” and “change to a different school.” The values assigned to the items are dependent upon the child’s age. Parents are able to fill in the Questionnaire for younger children.

Diagnostic Interview for Depression in Children and Adolescents Revised (DIDCA-R)/ Reich & Welner (1988): This interview examines depressive symptoms in children and adolescents. This is generally a highly structured interview, but interviewers (lay or trained) have the option to “go off topic” for response clarification. Items are manual-based, and include questions about hopelessness and suicide ideation. An algorithm was constructed to calculate depressive diagnoses based on endorsement of one or more cardinal symptoms and five total symptoms of depression (Reich & Welner, 1988).

Revised Children’s Manifest Anxiety Scale (RCMAS)/Reynolds & Richmond (1985): Child is asked to circle yes or no in response to 37 written statements describing feelings or behavior. An assessment of the level and nature of anxiety in children aged 6-19 years.

Social Adjustment Inventory for Children and Adolescents (SAICA)/ John et al. (1987): Contains a series of scales, including a new Peer Engagement scale, which taps heterosexual relationship items such as “doesn’t attend dances/parties,” “doesn’t date,” “doesn’t have boy friend/girl friend, friends of opposite sex.”

Spectrum of Suicidal and Assaultive Behaviors Scales/Pfeffer et al. (1993): These scales have been used to assess presence of suicidal behavior, as an instrument assessing “dangerousness” of suicidal and assaultive behaviors, and as an instrument theoretically linked to suicide potential.

Symptom Checklist-90-Checklist Revised (SCR-90-R)/Derogatis (1983): A brief, multidimensional self-report inventory designed to screen for a broad range of psychological problems and symptoms of psychopathology. It is also useful as a progress or outcomes measurement instrument, and is useful in both the initial evaluations of patients and for measuring patient progress during treatment.

Youth Self Report (YSR)/Achenbach (1991): This contains items similar to those on the CBCL, plus socially desirable items. Youths rate themselves for how true each item is now or was within the past six months, using the same three-point response scale as for the CBCL.
The Use of Children’s Drawings in the Evaluation and Treatment of Child Sexual, Emotional, and Physical Abuse

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Abstract: We reviewed the use of children’s artwork as a method of communicating individual and family functioning. A quantitative method of analyzing children's artwork provides more reliability and validity than some methods used previously. A new scoring system was developed that uses individual human figure drawings and kinetic family drawings. This scoring system was based on research with 842 children (341 positively identified as sexually molested, 252 positively not sexually molested but having emotional or behavioral problems, and 249 “normal” public school children). This system is more comprehensive than previous systems of assessment of potential abuse.

Introduction

Victimization of children, especially through physical, emotional, or sexual abuse, has received increasing amounts of attention from professionals and the media in recent years. Studies of adults in the United States have found that one in three girls and one in five boys are victims of sexual abuse as children (Ards & Harrell, 1993; Cappalleri et al, 1993; Cappalleri et al, 1993; Feldman et al, 1991; Finkelhor & Dziuba-Leatherman, 1994; Waterman et al, 1993; Vandenven & Emans, 1992; VanderMay, 1988). Current research confirms a tripling in the incidence of reported child sexual abuse since 1980 (Finkelhor & Dziuba-Leatherman, 1994; Kessel & Hyden, 1991; Wilkins, 1990). As adults and teenagers come forward and speak of their abuse, clinicians are becoming more aware of the devastation caused by this problem (Martin et al, 1993). Several studies during the past decade have generally confirmed the earlier research, which claimed a multitude of negative emotional and behavioral effects for male and female victims of child sexual molestation (Burgess et al, 1984; Faller, 1984; Kempe & Kempe, 1984; Leaman, 1980; Squier, 1982; Summit, 1983). In addition, the serious implications of delaying psychological treatments are realized.

Identifying and intervening with child victims of abuse can help prevent future emotional problems and medical symptoms (Walker et al, 1993; Watts & Ellis, 1993). Discovering abuse is hindered, however, by a child’s immature verbal expression, fear of revealing family secrets, or confusion about the meaning of abusive acts. Most children will draw, however. Through drawings children can communicate feelings and experiences that they may little understand or fear expressing aloud. Thus, they will “tell without telling” their story through their art productions. Providing art material for children is a “front line” approach to identifying and intervening on behalf of abused children who communicate covertly.

Although the meaning and analysis of children’s drawings have been investigated since the turn of the century, clinicians continue to be criticized for their over interpretation or their inability to decipher and quantify children’s art. As such, this method of communicating “secret subjects” remains under scrutiny or undervalued by police, courts, social workers, and health pro-
professionals, the system that is entrusted to provide child advocacy.

The purpose of this article is to introduce a practical approach to screening children’s drawings for indicators of abuse based on current research. Included is a step-by-step format for administering and interpreting child drawings for data collection. Scoring forms are introduced that can be filed in the medical record and reviewed over time. In addition, case examples illustrate important indicators in children’s drawings.

Detection of Sexual Abuse Indicators in Drawings

Peterson et al used a quantitative system to identify several indicators in Human Figure Drawings (HFDs) that are important in screening for sexual abuse. The seven most frequently occurring indicators are referred to as the “serious seven” (Table 1). Peterson et al developed specific criteria for scoring whether these indicators are present or absent in a child’s drawing. They found the “serious seven” indicators to be statistically significant in differentiating sexually abused from nonabused children when a factor analysis compared a population of 842 children, aged 6 to 10 years, in three groups: (1) those positively identified as having been sexually molested (341 children); (2) those positively not molested but having emotional and behavioral problems (252 clinically referred children); and (3) those “normal” children not identified as sexually molested or with emotional problems but possibly containing nonidentifiable features (249 public school children).

The first of those indicators identified as statistically significant was explicit drawing of genitals. Peterson et al found that 15.8% of molested children did this in their HFDs. Less than 0.5% of all other children, including the clinical referred group, included explicit genitals in their HFDs.

The second and third indicators also involved genital treatment. Peterson et al found that 14.7% of molested children demonstrated concealment of genitals. All other children did this less than 6.5% of the time. Third, Peterson et al found that 10% of all molested children omitted genital regions. All other children did this less than 5% of the time.

| Table 1. “Serious Seven” Indicators for Screening Children’s Drawings |
|---------------------------------|---------------------------------|
| Indicator                        | Description                     |
| Explicit drawings of genitals    | Penis, vagina, pubic hair, or breasts displayed |
| Concealment of genitals          | Drawn objects placed over genitals or breast |
| Omissions of genitalia           | Body midsection, genitals, and/or breast deleted |
| Omission of central part of figure| Absence of head or torso; “tadpole” figure |
| Encapsulation of drawing         | Figure partially or completely enclosed by lines |
| Fruit trees added                | Fruit tree spontaneously added and designated |
| Opposite sex drawn               | Figure opposite sex from child |

Although the therapist might think that the presence of genitalia in a picture is related to nudity in the home, access to sexually explicit materials, or sexual education, Hibbard and Roghmann (1995) determined that such practices were not associated with child drawings of genitalia. The presence of explicit genitalia in the drawings of a child of Western culture is a strong indication of possible sexual abuse.

The others of Peterson and coworkers’ serious seven indicators, after genital treatment, include omission of the central part of the figure, encapsulation of the HFD, fruit trees added, and the opposite sex drawn. Peterson et al found that 13.2% of molested children, 8.7% of the clinical referred group, and only 1.6% of the general population group omitted the central part of the human figure. Of all molested children, 4.2% encapsulated their HFDs; 14.1% of the general population and 15.9% of the clinic referred children also did this in their HFDs. These numbers are relatively high for clinical indicators in HFDs, but 42.2% represents a statistically significant difference from the other two groups.

The finding of fruit trees added to a drawing was the most unexpected of the Peterson et al data. These types of trees (usually apple or
The seventh indicator, drawing of the opposite sex by the child, was found to be critical for sexual molestation and emotional distress. In the sample of 849 children, 29.3% of molested children, 18.7% of clinic referred children, and only 9.6% of children from the general population did this. It is important that the drawing instructions given a child specify: “Draw me a person,” and not “Draw me a man or woman.”

**Detection of Physical Abuse Indicators in Drawings**

We know of no large quantitative study (similar to that of Peterson et al, 1995) that has focused on the art indicators specific to physically abused children. Qualitative interpretations of artwork by children from violent homes has been comprehensively covered by Wohl and Kaufman (1985). By compiling the qualitative interpretation and our clinical experience, the Peterson-Hardin quantitative HFD inventory (available from the authors) was developed to identify indicators drawn by physically abused children (i.e., jagged teeth, x’s for eyes). More quantitative drawing research is needed for this clinical population.

**Kinetic Family Drawing (KFD)**

The analysis of a child’s rendering of his or her family, including the child, “doing something” was first developed by Burns and Kaufman (1970). Kinetic family drawings (KFDs) have been shown to discriminate homes characterized by abuse, divorce, and juvenile delinquency (Reynolds & Kampaus, 1990). KFDs have also proved useful in obtaining information about school problems as well as identifying problems with self-esteem, body image, and affective states. The emphasis in the KFD is to interpret actions, styles, and symbols within the drawing to assess the presence or absence of perceived support from the family system. The child’s perception of himself or herself within the family network can disclose information not forthcoming from adult family members. Burns and Kaufman (1970) devised a useful method to screen family drawings that incorporated the quantitative and qualitative approaches. The basic concepts the clinician should consider when approaching the task of analyzing child KFD drawings are as follows: (1) concentrate on the initial feeling the drawing invokes; (2) act as a researcher; look at the size and the direction of the story (movement of the characters); (3) address focal points- shape, chaos, cohesion, missing items, placement; and (4) assemble individual components into a hypothesis with the child’s history and verbal responses (Furth, 1988).

**Screening Inventories**

The Peterson-Hardin KFD screening inventory is introduced, in part, in Figure 1, with our scoring of the drawing by the child described in case 1 (next page). The scoring inventory and meanings for KFDs provide a method of interpretation that is qualitative and quantitative. Initially, the examiner looks at the qualitative aspects of the drawings (peculiarity, feeling or emotion, and order or disorder). Next, the clinician evaluates the child’s perceptions of family and self (for size, shape, and distortion of family members in relationship to each other). Finally, the examiner uses a quantitative approach concentrating on the absence or presence of the following components: actions with negative aspects (aggression or weapons, fear or anxiety, etc.); treatment of figures (erasures, slanting, etc.). Once scoring is completed, the child is interviewed alone with the use of relevant questions (Table 2). Finally, a treatment strategy, including possible referral, is developed. In the following cases, the Peterson-Hardin KFD inventory was used to determine the presence or absence of indicators, as well as the overall mood, order, and peculiarity of the pictures.
The artist, Christy, is 8 years old; her sister Dena is 9 years old; and Mary is 4 years old. The mood of the picture (Figure 2) is “mixed emotions.” The picture is constructed in an orderly fashion, and some peculiarity is present. There is a discrepancy in size among the children and adults. In reality, Christy is about the same size as Dena, and Mary is considerably smaller; Christy’s mother is actually 157 cm tall and her father is 193 cm tall. The size of the family members demonstrates the child’s perception of their power or influence in the family. There is distortion in shape of the arms on Mary and Dad.

This child was initially referred by her school counselor for learning difficulties. Testing disclosed that she was very bright for her age, but highly affected by the dynamics in the
family. The mother was enduring domestic violence from the father. The father had just lost his long-term executive position and was unhappy to be employed as a truck driver. His sadness (buttons with sad faces drawn) and aggressive arms are clearly shown. The line between the parents represents a barrier or compartmentalization. Christy shows her angry mouth and later revealed that her father was physically abusing her, but not the other girls. Mary was perceived as “getting all the attention,” and Dena was admired for “being a good student” in school. Using the Peterson-Hardin KFD inventory for Christy’s picture, we found four KFD indicators (aggression, floating, extensions, and compartmentalization) and gave the drawing an overall score of “suspicious/refer”.

Dena, the 9-year-old, drew the same family through her perception as the oldest daughter (Figure 3). This is an organized drawing in realistic proportion, showing no quantitative KFD indicators.

The artist, 4 years of age, drew large explicit genitalia on all three figures (Figure 4). He identified his brother, age 6 years, to his right and his father to his left side. Note that the father is depicted with large arms, whereas the two sons have no arms. Quantitative analysis shows the picture to be peculiar, orderly, and disproportionate in size and shape, with excessive distortion in the depiction of the penis of each person. A total of four quantitative indicators are present (sexualized, incomplete figures, extensions, and underlining). The score on this picture is “suspicious/refer.” During an interview, both boys revealed they were sexually molested by their father on a recent weekend visitation. Referral by state-imposed protocols for abuse culminated in reporting the father to the authorities.

The artist, aged 8 years, drew excessively long arms and extensions (bats) depicting aggression by the male figure floating at the top of the paper (Figure 5). Note that the female figure below shows explicit damage by a hammer, a broken right arm, and shading to the face. Seven KFD quantitative indicators are present in this drawing (aggression or weapons; transparency; missing person [the child artist]; barriers; figure off baseline or floating; slanting figure; and extensions or long arms). Qualitative aspects of the picture show distortion of size (the male is

**Figure 3.** Kinetic family drawing by Dena for case 1.

**Figure 4.** Kinetic family drawing for case 2.

**Case 2**

The artist, 4 years of age, drew large explicit genitalia on all three figures (Figure 4). He identified his brother, age 6 years, to his right and his father to his left side. Note that the father is depicted with large arms, whereas the two sons have no arms. Quantitative analysis shows the picture to be peculiar, orderly, and disproportionate in size and shape, with excessive distortion in the depiction of the penis of each person. A total of four quantitative indicators are present (sexualized, incomplete figures, extensions, and underlining). The score on this picture is “suspicious/refer.” During an interview, both boys revealed they were sexually molested by their father on a recent weekend visitation. Referral by state-imposed protocols for abuse culminated in reporting the father to the authorities.

**Figure 5.** Kinetic family drawing for case 3.
drawn smaller) and peculiarity in that the male is linked to the female by a broken line. Use of the Peterson-Hardin KFD inventory results in a “suspicious/refer” score requiring interview of the child alone and referral. The child revealed that he had observed physical abuse of his mother by his father.

**Implementing the Drawing Method**

Although fairly simple, the drawing method is most valid when the suggestions listed in Table 3 are employed. In practice, the therapist provides materials and a setting (a small table or clipboard) so that the child can be instructed to draw either the human subject or the kinetic family while the clinician is taking a history from the parent. The child is asked, “Tell me about your picture,” using the drawing as a bridge to child communication. Ideally, one views it with the use of the inventory on the opposite side of paper. Any questions can then be asked of the child to clarify persons drawn and the meanings of some child markings.

### Table 3. Suggestions to Implement the Drawing Method

**Supplies:**
- Pencils
- Erasers
- Protractor (for evaluator)
- 8 x 11-inch white paper

**Instructions**

- **a. Human figure drawing:**
  
  “I would like you to draw me a picture of a person using just your pencil. I would like the drawing to be a whole person, not a stick figure- the best person you can draw.”

- **b. Kinetic family drawing:**
  
  “Draw a picture of everyone in your family, including you, DOING something. Try to draw whole people, not cartoons or stick people. Remember, make everyone DOING something: some kind of action.”

**Setting:**

Provide the child with supplies and instruction above and allow the child to draw while the physician takes a history from the parent.

**Scoring:**

Before performing the pediatric examination, pick up the child’s drawing and state: “Tell me about your picture.” Score the form on the opposite side of the page and determine the course of action (a more focused physical examination and/or child interview alone).

**Intervention:**

If the scored indicators, physical examination, and interview lead to suspicion, refer to the appropriate state agencies, designated by state law.

If enough indicators are present to warrant a score of “undetermined” or “suspicious/refer,” the physical examination can focus on emphasized (ie, genital area) body parts. Interview questions in Table 2 can be posed while the examination is being performed. Ideally the child is interviewed alone, as most children will not disclose family secrets in the presence of a parent or family member. Furthermore, immediacy is essential. Most children will talk at the time of the drawing but will “not remember” if questioned about it a week later. Finally, if the therapist waits for the next visit, a child’s rapport may be silenced by a suspicious adult.

**Scoring and Interpretation**

Initially, the developmental stage of the child’s work should be assessed. Children and adults often regress in stressful situations; thus, one might use a developmental perspective to compare the discrepancy between expected and actual art ability at a chronologic stage. Furthermore, many children in medical situations have chronic disabilities or acute medical conditions that might be limiting their ability to draw. It would be unfair to score a child’s drawing for emotional indicators when he or she in fact cannot perform the task.

Once a developmental perspective is gained, the HFD or the KFD inventory and scoring form are used to assess for psychological and/or emotional indicators. As a general rule, drawings represent the current experience of a child and must have two or more indicators to be of substantial concern. Collecting more than one drawing is also a more reliable approach to determining the degree of the problem the child is experiencing. Typically, older sexually abused children disclose subtle clues in initial drawings, followed by more explicit art in later productions (Peterson, 1990).

The context as well as the culture from which the child comes should always be factored into interpretation. As an example, children within the Tellensi in the Northern Territories of the Gold Coast (Cox, 1993) are known to draw explicit genitalia normally, whereas children within the Western culture do not. The Hardin-Peterson inventories have been found to correlate to the presence of abuse when
given the appropriate context of administration and interpretation.

The clinician should follow state regulations in reporting suspected abuse to child protective services once the collaborating data are gathered in addition to drawings. These data include health history from the parent, child physical findings, and a focused child interview. Data that might cause suspicion include recent changes in school performance or avoidance of school or other settings, such as the babysitter or relative’s home. Behavioral symptoms could include acting more withdrawn or acting out. Somatic complaints might include headaches, stomachaches, and changes in eating, sleeping, or dreaming patterns (nightmares). Findings on the physical examinations might include suspicious bruises, mouth sores, or redding in the groin, belly, or genital area. Unusual posturing, such as arching the back when placed on hands and knees for evaluation of the anal area, has been noted in children who have been sodomized. The Hardin-Peterson screening inventories do not diagnose physical or sexual abuse. They provide clues to the clinician that a child is attempting to communicate information that needs further investigation. Interested readers who wish more information on the criteria for indicators or for procuring HFD and KFD screening forms may contact us.

Conclusions

The use of art in the examination of children for potential abuse has several distinct advantages: (1) Children are likely to engage in art activity, which allows for a self-directed, gradual relating of their experience, rather than a time-urgent adult interview. (2) A growing body of literature documents an unconscious need for children to reenact the trauma they have experienced (Terr, 1981). Reenactment in the form of art and play is healthy and positive. Art also allows for tension release, as the child’s mental energy is redirected from dealing with strong emotions secondary to the trauma to focusing on an artistic expression of his or her emotions. Furthermore, this redirection enables the child to attain new perspectives and insights into the trauma. Finally, the child’s art production on paper can later be shared with others who experienced the same situation. (3) Children’s drawings represent an intervention that is easily implemented, at minimal cost, in a hospital or health care setting where children who have experienced trauma are being treated.

On review of the cases, the value of quantifying drawing indicators and using the quantitative approach to interpretation is apparent. This art screening method can be compared with the structure provided by the Denver Developmental Screening Test, which determines developmental delay (Frankenburg, 1990). The child draws on one side of the paper and the work is scored on the other page, making the form suitable for filing within the child’s medical record. As you implement the Peterson-Hardin KFD forms, the practicality of this method becomes apparent. Any conclusions or findings noted on the form can be validated by asking a colleague to view the same drawing to determine validity and reliability.

Because traumatized children are known to reenact traumatic events, their artwork may be one of the first indelible expressions of their life experience. As advocates for children, the clinician who knowledgeably screens child art productions is in a key position to prevent further trauma.

Editor’s note: Milton E. Hardin, MA, was solely responsible for the research reported on the human figure drawings regarding 842 children evaluated for art indicators of sexual abuse.

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The author is attempting to clarify, in a formal, research-based manner, the difference (and likeness) of Post-traumatic Stress Disorder (PTSD) and Disorders of Extreme Stress Not Otherwise Specified (DESNOS). Previous studies found the two to be comorbid, but still different in some fundamental ways. The population in the study was military veterans seeking inpatient PTSD treatment. While this population does not directly relate to the readership of this journal, some of the findings are of definite interest. The author clearly delineates the problems with the study, and is open about the necessity for further attention to this issue, both from a theoretical sense as well as a research approach. He does an excellent review of the literature and it is obvious that he is extremely well versed in this area of trauma research.

The research design was well conceived and three complex hypotheses were developed. These were 1. DESNOS and PTSD should differ etiologically only in DESNOS's association of severe early childhood trauma and PTSD's association with severe combat trauma. 2. DESNOS and PTSD should differ quantitatively but not qualitatively in their association with symptomatic or impairment severity. 3. Both DESNOS and PTSD should be associated with an elevated likelihood of utilization of the most costly and intensive psychiatric treatment services, compared to similar PTSD-treatment-seeking individuals who do not meet criteria for DESNOS or PTSD. Data from the various instruments and interviews were quantified and appropriate statistical methodology was followed.

The results indicated that hypothesis 1 was supported and 2 & 3 were not supported. Further, the results suggested that PTSD and DESNOS are comorbid but apparently distinct post-traumatic syndromes. The population consisted of 84 veterans. Using the assessment tools, including the Mississippi and Penn PTSD measures, 31% qualified for both conditions, 29% were diagnosed with PTSD only, 27% were diagnosed as DESNOS only and 13% met the criteria for neither. Among the trauma correlates that distinguished the two entities was early childhood trauma. This was one of the defining characteristics of DESNOS, and not PTSD. The article is a sound research work, which is addressing the fine-tuning of the assessment and diagnosis of trauma victims. This work and its subsequent efforts will have direct and important implications for the nature of treatment and intervention. Of particular importance to those who work primarily with children is the solid reinforcement of the necessity of early intervention.
This article presents extensive information on a model of conceptualization and intervention for juvenile delinquency. Findings may be of interest to those who work in school settings because they address issues of juvenile offenders who become dangerous to peers and personnel. Of particular concern is the dramatic attention placed on violent offenses committed by adolescents and the pervasiveness of adolescent violence and repercussions of such violence on schools, communities, and the youth themselves.

The model presented in this article includes the characteristics of juvenile offenders, the environmental factors that impact behavior, and the interactions among these variables. The authors offer specific interventions to address these variables; and a specific service, training, and research project exploring these interventions is described: Juvenile Counseling and Assessment Program (JCAP). This program utilizes a collaborative approach involving university counseling faculty, educators, counseling students, and the juvenile court system to determine how to reduce juvenile delinquency and increase adaptive skills in adolescents at risk.

JCAP currently provides services to a diverse population of court-referred youth, providing therapeutic services to approximately 120 juvenile offenders. The youth represent diverse racial, ethnic backgrounds, and socioeconomic status, and range in age from 9-17 years. They attend either public, private or alternative schools (defined as self-contained, highly-structured schools for disciplinary referral) and some of the youth may also be detained at a regional youth detention center. Offenses include truancy, runaway, underage consumption of alcohol, burglary, and aggravated assault.

This article is particularly recommended to those who work with adolescents at risk for delinquent behavior and to school counselors working with adolescents. An interesting case study is provided to take counselors through the various aspects of intervention and helps to illustrate the salient points of the authors research. In addition, a copy of the manual used to structure intervention, provide therapeutic services, and delineate appropriate activities is available from the first author at <gcalhoun@arches.uga.edu>.

Cathy A. Malchiodi, ATR, LPAT, LPCC, is the Director, Institute for the Arts & Health and advisory board member, The National Institute for Trauma & Loss in Children, author of numerous books including, Understanding Children’s Drawings (1998) and The Art Therapy Sourcebook (1998), and published over 50 articles and chapters on the use of art intervention with children. Cathy has given more than 140 invited keynotes and presentations throughout the US and the world and is the editor of Trauma & Loss: Research & Interventions.
Babette Rothschild has produced a masterful book! This text should be required reading for all therapists, particularly those engaged in trauma work. The book is divided into two major components. Part One is Theory; Part Two, Practice. In Part One, Rothschild does an excellent job of synthesizing the research of the neurological basis of emotion. Her writing style is such that a person unfamiliar with the brain and brain research would have little difficulty following her exploration of this complicated subject matter. To set the stage, Rothschild provides a thorough overview of Posttraumatic Stress Disorder (PTSD) and its impact on the body and mind, emphasizing the need to take heed of the emotional, mental and physical dimensions of trauma in any treatment intervention.

A particularly informative chapter in Part One is devoted to brain development, an area grossly understudied by the majority of therapists. This chapter serves as the physiological basis for the development of her theory regarding somatic memory and her consideration of the senses as the primary roots of memory. The autonomic nervous system is well defined, especially with regard to hyperarousal and the reflexes of fight, flight and freeze. Her use of diagrams and vignettes make for increased clarity and understanding of this complex subject matter. The concept of the somatic nervous system, including muscles, movement and kinesthetic memory is explained, once again using written and visual explanatory techniques. This rather technical portion of the book is followed by a most informative chapter entitled, “Emotions and the Body.” Rothschild presents, in a brief but concise manner, an overview of the history of the emotion-body connection. The author describes the physical sensations of emotions, the physical behaviors that go with emotions, and how our daily speech is laden with words and phrases which reflect the link of emotions and body, psyche and soma. To demonstrate the theoretical concepts being dealt with in the text, Rothschild provides participatory experientials for the reader to do so that the reader actually experiences and feels these sensations and percepts as they are presented. The final section of this chapter addresses emotions and trauma. Part One concludes with a chapter on expressions of trauma not yet consciously acknowledged by patients, including dissociation and flashbacks.

Part Two deals with putting this knowledge and understanding of the brain-- its development, and the neurological and physiological basis of emotions-- to work for the therapist dealing with trauma victims. Most impressive

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John G. Jones, PhD, ABPP, ATR-BC, was born in New Mexico and grew up in northwest Texas. He attended Hardin-Simmons University, Texas Tech University, and received his PhD from the University of Wisconsin-Madison. He completed internships in counseling and clinical psychology, at the University of Texas-Austin and Bethesda Navy National Medical Center, respectively. He has had extensive clinical experience working with a vast range of trauma victims and has made multiple presentations and published articles in this field.
was the author’s sensitivity and ultimate concern for the welfare of the patient. Rothschild repeatedly stresses the necessity of a careful, sensitive and slow approach to this type of therapeutic endeavor. She teaches and demonstrates how to provide the patient with a safe place to go if the going becomes difficult, how to put on the brakes, and the freedom to do so. In keeping with the emphasis of the physiological basis of emotion, she teaches the patient (and the reader/therapist) to monitor the outward manifestations of the autonomic and parasympathetic nervous systems. In this very real manner, both the patient and therapists have a somatic-based gauge to go by when dealing with the often volatile subject matter of trauma therapy. She liberally uses clinical case study material to demonstrate each method and technique presented.

Rothschild is very open in discussing the strengths and weaknesses of her approach. She presents some case studies of failed therapy and addresses the reasons for this failure. The emphasis on not re-traumatizing the patient is reiterated and is of major therapeutic concern, thus her emphasis on building a system of safeguards for the patient as the initial effort in therapy.

I found this book to be the best example of an attempt to demonstrate the reality of the emotional brain, and how a clear understanding of the entire brain-body relationship can contribute to effective therapeutic intervention. This is a text that emphasizes the understanding and use of the entire array of resources patients have available to them in the process of psychotherapy, and does so with a clarity, sensitivity and thoroughness that at once is refreshing and remarkable. While it is directed at the treatment of trauma per se, the techniques and understanding of the physiological nature of emotion can be applied to virtually all therapeutic approaches.

One issue that may be worth addressing is Rothschild’s adaptation of Lenore Terr’s (1994) “Trauma Types.” Type I refers to individuals who have experienced a single traumatic event, and Type II is assigned to individuals experiencing multiple traumatic events, further distinguished by those who have differing backgrounds and/or personal resources to deal with their trauma. The problem with this scheme lies with Type I and the author’s assertion that these single traumatic events are generally more quickly addressed and resolved. For instance, the victims and survivors of the Oklahoma City bombing, for the most part, suffered a single traumatic incident. However, the magnitude and the global effect on the individual were tremendous and devastating. In a word, I would suggest caution about not carefully assessing the nature of the trauma in a single trauma patient.

This book is a clear pacesetter in integrating the physiological and psychological dimensions of emotions and the use of such knowledge in the therapeutic process. I hope this pioneer author continues her excellent work, to stimulate and educate about the total beings that we are.

Once again, the renowned author of textbooks, journal articles and videos, Judith Rubin, has created a groundbreaking and indispensable volume about the profession of art therapy. In this volume she takes a wide angle “overview of the field” (p. xix) including its history, current practice and the potential evolution of a profession that is in process. The book definitely accomplishes its aim to introduce the reader to all of the main ingredients of the profession. In addition to acquainting the reader with art therapy, Rubin provides numerous vignettes and an exhaustive reference and resource list to tantalize the mind with ideas that may be explored elsewhere in further depth. She also discusses the 3-D or “tripartite learning package” (p. xx) that will follow up this volume and more aptly reflect the multidimensional aspect of the field of art therapy. The format will be audiovisual in nature and will include the combination of both doing and reflecting that are so integral to this modality. The author also strongly promotes the active involvement of the reader in a workshop experience or participatory mode to really grasp the remarkable power of the process.

Art Therapy: An Introduction is divided into twelve chapters beginning in Chapter 1 with visual images of many founders in the field, and with short vignettes of the art therapy process with varied clientele. In Chapter 2, the author defines the parameters of art therapy and describes its use within educational and medical settings. She also describes its uses as part of play therapy, child life and art counseling programs as well as discussing clinicians who use art in therapy. Chapter 3 reviews the history and related influences that fostered the birth of art therapy in the United States and pays tribute to the parallel development of art therapy in England and Canada. Chapter 4 includes the required education for competent art therapy practice. It describes relevant art therapy credentials, professional identity, and the importance of both public and political awareness for its professional growth. Chapter 5 explores the art part of art therapy including the materials, the processes, and products. It explores the therapy part encompassing the dynamics, planning, pathology, the therapeutic relationship, and the process of change. This chapter concludes with the amplification of the advantages of the creative art process for healing. Chapter 6 provides a survey of theoretical orientations that are often utilized in the application of art therapy. Chapter 7 focuses on diagnosis, assessment, and the general practice of art therapy with different populations, leading the reader to the artistic, motivational, and multimodal approaches utilized in facilitating expression in Chapter 8. Chapter 9 further delineates the diversity of the disabilities, issues and ages of individuals that art therapists may serve, while Chapter 10 portrays the numerous expansion of places where art therapists practice. These include medical, education-
al, and rehabilitation centers, as well as bereave-
ment settings, crisis centers, and even commu-
ity centers. Chapter 11 describes the standards for 
educational programs and individual practice. It 
covers ethical issues and how to evaluate 
research in art therapy. In conclusion, Chapter 
12 defines numerous ways to discover and expe-
rience more on the subject of art therapy as a 
process, a career, and its future.

Of particular interest to readers of Trauma 
and Loss in Children: Research and 
Interventions are the sections of this book which 
relate the unique aspects of art as a therapeutic 
intervention. Those aspects include the ability to 
provide simultaneous and sequential depictions 
of time and space within a single picture. Art 
fosters synthesis and integration, without words, 
while allowing reflective distance between the 
client, therapist, and externalized aspects of the 
self projected into the art. Rubin highlights what 
she and other art therapists have found, that art 
provides a safe place to experiment with danger-
ous situations, topics, and affects (Calisch, 
1994); that art is a way to know (Allen, 1995) 
and tell without talking (Cohen & Cox, 1995). 
It is an opportunity to listen with our eyes 
(Jakab, 1981), and it is medicine (McNiff, 
1994).

Particularly pertinent to trauma and crisis 
is the fact that often, these memories of trauma 
are frequently preverbal and stored in the brain’s 
right hemisphere. The two ways of processing 
memories, the imaginal mode and the verbal 
mode, are associated with the differences in the 
functioning of the two hemispheres. Verbal pro-
cessing is predominantly associated with the left 
hemisphere, while imagery is associated with the 
right hemisphere. The interaction between these 
two modes of information processing increases 
the possibility of creative solutions and is intrin-
sic to the art process. Rubin relates through ref-
ences and detailed case examples, the benefits 
of art therapy with abused children, their family 
members, with substance abusers, dissociative 
disorders, and incest victims. She describes how 
art therapy is also utilized as a therapeutic inter-
vention with posttraumatic stress disorders such 
as combat stress and other horrors of war. It is 
used to debrief persons who experience natural 
disasters and violence of all kinds. More typical 
stress situations such as custody battles, divorce, 
blending families, adoptions, and community 
tensions can be aided by art therapy interven-
tions. People in all kinds of crises—personal, 
medical, social, economic—can be helped to 
master them through art therapy.

Although comprehensive overviews often 
provide information in a diluted form, Art 
Therapy: An Introduction evades this pitfall. In 
fact, the volume offers something for everyone 
in an incredibly thorough yet condensed form. 
For the novice, the book provides a wealth of 
information about the history, theory, and the 
diversity of the profession through case exam-
pies, quotes from many art therapists, and pho-
tos. For the professional, the volume provides a 
longitudinal reflection of the progress of the 
field and portrays an endless number of accom-
plishments from historical and contemporary art 
therapists. The author truly provides a rich array 
of information in her rubenesque, straight for-
ward manner that is sure to satisfy all who read 
and digest it, regardless of their level of expert-
ise.

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Shambala Press.
In the days following the horrific events of September 11th, trauma specialists scrambled to find resources to help young clients. There were numerous requests for resources to manage the nightmares, decrease stress levels, gather ideas for altruistic activities, address bigotry and hatred as well as develop group activities to enable people to come together. The need to know what to say, how to reach out to others, and how to assist families and clients were also common concerns.

It is widely known that children need information to counterbalance the misinformation that is readily accessible. The task at hand becomes providing that information in a developmentally age-appropriate manner. We have also learned that in times of crisis and grief, attention spans are limited, and so the amount of time one can focus on the words of the books must be considered. A tip might be “less is more.”

The following is a list of trauma-related resources that may be of help to trauma specialists, parents, teens, and children:

- The National Institute for Trauma and Loss in Children (TLC) has created an extensive library of practical hands-on tools. These trauma resources are jewels that offer detailed guidance for helping professionals to use in these challenging times. What Parents Need to Know: Help for Parents of Grieving & Traumatized Children by William Steele is an excellent place to start for caregivers and parents. It has an easy to read format explaining trauma, expected behaviors, and some beginning steps toward healing those who hurt. Two other booklets, You are Not Alone (for children ages 6 to 12) and A Trauma is Like No Other Experience (for teens) are directed to these traumatized children.

- Parents often are concerned that if they say too much too soon they will frighten their children. My experience has been that you will soon know, by the signs children provide, when it is over their heads. Some helpful books that assist parents with helpful dialogues include How to Talk to Your Kids About Really Important Things and How to Talk to Teens About Really Important Things both by Charles E. Schaefer, PhD and Theresa DeGeronimo, M.Ed., Children and Trauma by Cynthia Monohon, and Parenting through Crisis by Barbara Coloroso. Books by respected grief authors Alan Wolfelt and Earl Grollman provide some concrete answers which parents may be seeking, as well as Keys to Parenting Your Anxious Child by Katharina Manassis, M.D., F.R.C.P. will be helpful.

- Parents and children can benefit from good books that help children learn to identify and express their feelings. There are so many outstanding books on this subject. A few of my favorites are Just Because I Am and the Leader’s Guide that accompanies this title.

Deanne Ginns-Gruenberg, BSN, LPC, RPT-S, is a TLC special presenter and a registered play therapist with over 25 years experience. She is also owner of the Self-Esteem Bookshop in Royal Oak, Michigan.
Double Dip Feelings gives children permission to have more than one feeling at the same time. More pertinent than ever, my favorite book for traumatized children is Brave Bart (see review in V. 1, #1, Trauma and Loss: Research and Interventions). While some children relate well to people-characters, I frequently note that animal characters are especially appealing and engaging to children, especially in these difficult situations. Children identify with the animal characters in this story and are encouraged to believe that they too can surmount the issues which confront them.

- For classroom use after the terrorist attacks on September 11th, I suggest Sailing Through the Storm by Edie Julik. A sailboat on the water of life is “happily sailing along in calm, blue water. Suddenly there is a big boom. Someone has been hurt, and everything changes.” “Violence has happened to you, or to someone you know, or even someone you have never met.” So begins this interactive book that serves as a springboard to initiate discussion and expressive activities. The metaphor of sailboats on the water of life is an empowering tool that offers a sense of hope. Speaking directly to the children, it captures a wide range of emotions which include feeling like your “little sailboat is going to sink;” and moves in a positive direction encouraging children to express those scary feelings. Sailing Through the Storm affirms that within each of us lies the power to make a difference and sail towards the ocean of peace.

- When Something Terrible Happens by Marge Heegard, is a venue for children to express their fears and hopes. Simple explanations are on each page, and the children are invited to draw and discuss their work. To help children cope with nightmares, two of my personal favorites are Jessica & the Wolf and Annie Stories. Jessica models different coping techniques including reworking her nightmare - giving it a healthier ending. Annie Stories is a collection of stories on numerous topics in which the author actually provides footnotes for the caregiver. These explain the rationale for specific strategies which characters model.

- Additionally, soothing audiotapes or cassettes played at bedtime can help decrease anxiety and stress levels. Books like Starbright, Earthlight, and Moonlight provide calming guided imagery and affirmations for elementary age children. Roxanne Daleo has created some beautiful stories on audio to help children unwind. Ready Set Relax by Jeffrey Allen and Roger Klein, a favorite of many play therapists and caregivers, is an outstanding tool with calming scripts for the active imagination. These are followed by specific activities and questions for discussion. The scripts, put to music, are available both in a CD and cassette format called Ready Set Release, and are valuable for all ages.

- The importance of expressive therapies cannot be understated in its contribution towards the healing process. Understanding Children’s Drawings by Cathy Malchiodi is an essential tool, providing practical guidelines for art therapy including helpful questions to explore with children. Clinicians will find the suggestions in another book on art intervention, also by Malchiodi, applicable to all children affected by our recent tragedy. Children in Distress: A Guide for Screening Children’s Art by Linda Peterson and M. Hardin provides assistance to therapists in identifying signs of childhood trauma. Those working with adolescents will find Contemporary Art Therapy with Adolescents by Shirley Riley a welcome companion to assist this population in communicating their concerns.

- Equally important is play therapy, and there are numerous books that can help trauma specialists get started. In a new book, School-Based Play Therapy, edited by
Athena Drewes, Lois Carey, and Charles Schaefer, Athena has written an excellent, relevant chapter, “Developmental Considerations in Play & Play Therapy with Traumatized Children.” In Treating Traumatized Children Beverly James shares clinical situations and specific interventions. Any of Eliana Gil’s books or chapters on the subject of abused and/or neglected children and adolescents can be adapted when working with traumatized youth and families.

• Trauma specialists often need resources to help children make sense of what happened. Sandtray offers a soothing medium for children of all ages to begin the healing process. A great place to start is with Sandtray: A Practical Manual by Linda Homeyer and Daniel Sweeney; this medium facilitates children as they move towards feelings of safety and empowerment. Sandplay Therapy with Children and Families by Lois Carey will be of value to those working with families. In Sandplay Therapy by Barbara Boik and E. Anna Goodwin, the attention given to multicultural aspects takes on added value and importance, at this time.

• Why do people hate other people? This question has been asked with increasing frequency and begs to be answered. Why is Everybody Always Picking on Us, assists us to look at the roots of prejudice, and will be a useful tool for educators and clinicians. Children of Color by Jewelle Gibbs suggests important considerations when working with clients of different nationalities or races.

• What will be most valuable to those of us working with traumatized children? There are so many available outstanding materials; this list is far from exclusive. Two outstanding resources that will provide a helpful overview for us are Too Scared to Cry by Lenore Terr, MD and Trauma and Recovery by Judith Herman. Both clearly articulate the impact of trauma.

• Practical resources to help the helper are also needed. What Color is Your Hurt? for preschool children, I Feel Better Now Curriculum, for ages 6-12, and Trauma Response Intervention are available from The National Institute for Trauma and Loss in Children to guide the helper in working with children in groups. Children begin the healing process as they express their thoughts, concerns, hopes, and dreams in clearly defined age-appropriate activities. A new manual, Adults and Parents in Trauma: Learning to Survive, a new TLC intervention, recognizes the need for parental involvement and offers specific therapeutic interventions to facilitate healing. Trauma Debriefing for Schools and Agencies is an essential tool for every debriefer. I also suggest Three Dimensional Grief: Model for Facilitating Grief Groups for Inner City Children by Dottie Ward Wimmer, Carol Napoli, and Sarah Outman Brophy. Kathryn Brohl offers helpful ideas in Working with Traumatized Children: Handbook for Healing. The detailed case studies in Helping Bereaved Children: A Handbook for Practitioners, edited by Nancy Boyd Webb, also offers valuable guidelines and considerations for treatment.

Of course, the most important resources are the children themselves. Books are important, but more important is that we truly listen to the children with whom we are working, allowing them to guide us in their journey. In so doing, we may create the best healing tool yet.

Resources for People Helping People
and People Helping Themselves

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