Abstract: The traumatization of child sexual abuse does not end with the criminal act itself. Young victims’ participation in the multiple systems purporting to assist them can lead to retraumatization, the second insult. Counselors who work with children need to be aware of how variables such as prior child sexual abuse, the male as victim, victim characteristics, caregiver and family characteristics, and whether or not the crime was reported can affect the level of emotional health and recovery for these children. Current literature examines the effects of many of these variables on an individual basis. In order to help reduce the chances of young victims being revictimized counselors need to look at how these variables interact with each other and manifest themselves in the systems helping children. Assisting young victims of abuse includes having an understanding of the theories of child maltreatment. Implications for counselors in regard to the second insult include the development of competency in the realm of child sexual abuse and treatment, collaboration between multiple systems, and implementation of specialized programming. Case vignettes are provided to illustrate the variables of retraumatization.

The world of the victim can be an isolating and surreal place. This world becomes even more disconcerting when it is viewed through the eyes of a child victim. Then, to confound matters, the child victim may become retraumatized when those entrusted with the duty to help do so in an incompetent or indifferent manner. For example, one may not be appropriately trained in dealing with child sexual abuse or may not have a true empathy or understanding of the victim.

The consequences of victimization can be devastating. The victimization experience includes enduring emotional anguish and interpersonal complications (Doerner & Lab, 1998). Many victims do not receive the necessary help to cope with these problems. In addition, if a victim enters the criminal justice system that victim may become frustrated, confused, angry, and bewildered by the response received from the...
criminal justice system. The first insult, according to Doerner and Lab (1998) is the criminal victimization itself. The victim suffers at the hands of the offender. The second insult, however, comes at the hands of the criminal justice system. Participation in the criminal justice system can lead to further victimization (Doerner & Lab, 1998) and thus retraumatize the child sexual abuse victim. Extending the concept of the second insult, retraumatization can occur due to other variables in addition to participation in the criminal justice system. The victim can be retraumatized by other systems, such as the helping profession, the medical profession, and the family. Additionally, increased chances for retraumatization can occur as a result of these variables interacting with each other.

THE VARIABLES OF RETRAUMATIZATION

While the variables that lead to the retraumatization of the child abuse victim are many, some of these aforementioned variables are repeatedly found in the literature. Helping professionals are encouraged to be aware of these variables and how they may adversely affect the victim and successful treatment. Additionally, helping professionals are encouraged to investigate the combined unique effects for the risk of retraumatization. This combined effect, according to Brown, Cohen, Johnson, and Salzinger (1998), was associated with significant increases in risk for abuse and neglect of all types. The variables of retraumatization most noted include prior child sexual abuse, the male as victim, victim characteristics, caregivers and families, and reporting versus non-reporting.

Prior Child Sexual Abuse

Collins (1998) reported that becoming a victim of sexual aggression has been linked to an increased probability of being victimized again. This seems to hold true for women who were sexually abused as children (Collins, 1998). The experiences of sexual abuse in childhood seem to have ramifications on psychological functioning and interpersonal relationships later in life. Several studies have found a link between child sexual abuse and the probability of being revictimized in later life (e.g., Collins, 1998; Krahe, Scheinberger-Olwig, Waizenhofer, & Kolpin, 1999; Layman, Gidycz, & Lynn, 1996; Messman & Long, 1996). According to Messman and Long (1996), approximately 72% of females who experienced child sexual abuse will be revictimized later. This finding is consistent with Layman et al. (1996) who found increased risk of victimization occurs when women were sexually abused as children. Further, in studying childhood sexual abuse as a risk factor for sexual victimization in adolescence and adulthood, abused women reported substantially higher frequencies of unwanted sexual intercourse through verbal pressure (Krahe et al., 1999). The nonvictimized sample, according to Krahe et al. had lower frequencies of unwanted sexual experiences than the groups that were unsure about being victimized or that were victimized sexually as children. Krahe et al. also reported that respondents with a childhood history of sexual abuse were at risk for the more severe forms of sexual revictimization. This revictimization included reports of attempted and completed rape by means of alcohol or force. Additionally, "Women who reported sexual abuse as children had a significantly higher number of sexual partners which was in turn related to higher levels of victimization" (Krahe et al., p. 391). Krahe et al. concluded that childhood experiences of sexual abuse constitute a significant risk factor for subsequent revictimization. Thus, the long-term effects of childhood sexual abuse in relation to later sexual behavior and vulnerability to revictimization are clearly evident. Creating intervention strategies for sexually abused girls will aid in creating awareness of the potential vulnerability to retraumatization. These strategies may also promote insight into the dynamics of the revictimization cycle where abuse gives rise to more abuse. Finally, these strategies may enable the child abuse victim to protect against a recurrence of the trauma of sexual assault.
The Male as Victim

Jason, Williams, Burton, and Rochet (1982) found girls are at a greater risk than boys for sexual abuse. However, boys outnumbered girls in all types of abuse and neglect except sexual abuse (Rosenthal, 1988). Further, according to Rosenthal (1988), higher rates of serious and frequent injury occurred in boys. These injuries include rectal lacerations, abrasions, fecal leaking, and scars. Injury rates ranged from 32 to 68 percent. Grayson (1989) found "perpetrators engage in a wider range of sexual activity with boys and boys are more likely than girls to experience anal intercourse, oral-genital contact, ejaculation and mutual masturbation" (p. 4). MSNBC News (2001) reported child sexual exploitation affects as many boys as girls. This finding, according to MSNBC (2001) is contrary to popular belief and may be a result of several factors. First, Estes and Weiner (2001) found that “boys are less well served by human-service and law-enforcement systems because of the widespread belief that boys are better able than are girls to fend for themselves” (¶ 10). This may add to the reality that boys tend to have a heightened sense of victimization as they are not socialized to the role of victim (Blanchard, 1986; Rosenthal, 1988). Next, research on child sexual abuse may not have been representative of males. For example, female subjects dominate studies on the prevalence rates of victimization (Grayson, 1989). Finally, parents may not bring male children to treatment as often as female children. For example, some parents may believe sexual activity in young boys to be experimental in nature and do not consider this activity a form of abuse (Grayson, 1989). However, according to Grayson (1989), "Boys who are sexually abused appear to suffer many of the same effects as girls" (p. 4). These effects include sleep disturbances, agitation, highly sexualized behaviors, and excessive masturbation (Grayson, 1989). Further, some effects may be specific to males. For example, male victims tend to feel more confusion about their sexual identity, they feel concerned that they may also become a perpetrator, and they have a fear of Acquired Immune Deficiency Syndrome (Grayson, 1989; Porter, 1986).

Victim Characteristics

Kalichman (1992) observed older abuse victims were consistently being ascribed a greater responsibility for the assault than younger abuse victims. Further, Bell, Kuriloff, and Lottes (1994) reported that female sexual assault victims were more frequently depicted as being provocative instigators of their own abuse. In cases of rape, Bell et al. report that males assign more responsibility to victims. In a study conducted by Back and Lips (1998) on the effects of victim age, victim gender, and observer gender, these authors found that older children were ascribed more responsibility than younger children for their victimization. They also found that male helping professionals attributed more responsibility to the victim than did female helping professionals. Male helping professionals also attributed more causality to the victim than did female helping professionals. Thus, sexually abused children are more likely to be held responsible for their abuse when they are older, when the observer is a male, and when the observer perceives him or herself as personally dissimilar to the victim. Therefore, the conceptual distinction between responsibility, blame, and causality warrants further consideration. These findings have serious implications regarding the treatment of the victim. They also represent the second insult, or retraumatization.

Caregivers and Families

According to Gray, Pithers, Busconi, and Houchens (1999) "An increased frequency of sexual behaviors is one of the most common aftereffects of childhood sexual maltreatment" (p. 602). Highly sexualized behaviors such as touching, fondling and protracted genital stroking, sexual invitations, gestures of graphic or threatening imitation of sex acts, and exposing oneself were most common. The second most common aftereffect, according to Gray et al., was the diagnosis of Posttraumatic Stress Disorder (PTSD). It was reported that 96% of sexually abused children met the criteria for at least one Diagnostic and Statistical Manual-Fourth Edition disorder (Gray et al.).
There is support from the literature to suggest that many child victims live in a family environment that deters their recovery from maltreatment (e.g., Fergusson, Linskey, & Horwood, 1996; Finkelhor, Hoteling, Lewis, & Smith, 1990; Salzinger, Feldman, Hammer, & Rosari, 1992; Whipple, & Webster-Statton, 1991). These family environments include poor family and parent-child relationships, use of severe physical punishment, frequent punishment for moral transgressions, conventional social transgressions, and conflict between parents. Further support from the literature suggests that the parents of these children may have maladaptive personality characteristics, substance abuse problems, domestic violence incidents, lack of community involvement, and possibly been victims of abuse themselves (e.g., Fantuzzo, Borach, Beriama, Atkins, & Marcus, 1997; Kaufman, & Zigler, 1987; Kelleher, Chaffin, Hollenberg, & Fischer, 1994; Lawson, & Hays, 1989; Polansky, Gaudin, Ammons, & Davis, 1985). It is important to note, “the sexual exploitation of children is not limited to particular racial, ethnic or socioeconomic groups” (Estes & Weiner, 2001, 11).

Results of a study conducted by Gray et al. (1999) indicated that physical violence and criminal activity among family members were reported to be high among subjects who had problematic sexual behavior. Family problems, such as substance abuse, poverty and economical strains, parental capacity and skills, and domestic violence are also identified as contributing to child maltreatment (Center on Child Abuse Prevention Research, n.d.).

According to Pithers and Gray (1990), the family can play an essential role in aiding a child's recovery from sexual abuse. The aforementioned family and parent characteristics make it less likely families would use supportive services (Staudt, Scheuler-Whitaker, & Hinterlong, 2001). Hunter and Figueredo (2000) found that sexually abused children who later acted abusively as juveniles had more unsupportive family members. In addition, Pithers, Gray, Busconi, and Houchens (1998) reported that the caregivers of sexual abuse victims had an impaired attachment with their children. In the families of children with sexual behavior problems, Pithers et al. (1998) reported that parents viewed their children as possessing qualities that they considered disappointing or undesirable, such as being distressed, depressed, or overly demanding. For example, White, Benedict, Wulff, and Kelley (1987) found disabilities increase risk for maltreatment. Other parents, according to Gray et al. (1999), participate in unhealthy relationships, reinforce or model inappropriate behavior such as inconsistent discipline and send mixed messages regarding appropriate behavior. Further, “The children who had engaged in developmentally unexpected sexual behaviors had experienced a wide range of traumatic events, some of which had been inflicted by their immediate family” (Gray et al., p. 618). The family is purported to be the one institution in which we should be able to entrust our security. However, sometimes those close to us perpetuate the second insult, whether knowingly or not. Therefore, it is recommended treatment include concerns for family mental health.

**Reporting Versus Non-Reporting**

Many sexually abused children do not immediately disclose their assaults. These nondisclosures result in a significant number of cases not coming to the attention of the agencies that investigate these crimes. Nondisclosure also results in a lack of protective measures to reduce the likelihood of future abuse. According to Hanson, Resnick, Saunders, Kilpatrick, and Best (1999), "Research aimed at identifying factors that increase the likelihood of immediate abuse reporting could have important legal and mental health benefits" (p. 560). Further, several studies have examined the reasons why children may not immediately disclose their assault (e.g., Herman, 1981; Lamb & Edgar-Smith, 1994; Lawson & Chaffin, 1992; Sauzier, 1989; Springs & Friedrich, 1992). Lawson and Chaffin (1992) report that children may not disclose their assaults due to feelings of guilt and self-blame. Additionally, fears related to retaliation by the offender, being blamed, or not believed by others may reduce the reporting of abuse. Arata (1998) found that disclosure was not directly related to
overall current functioning, but was associated with fewer symptoms of PTSD, specifically intrusive and avoidance symptoms. Victims do not always view disclosure positively. Some victims tend to view disclosure as unhelpful or potentially humiliating. However, in the study conducted by Hanson et al., no significant differences were found in the prevalence rates of PTSD for reporters versus nonreporters. There appear to be equivocal findings on whether failure to report is related to long-term mental health problems. Yet, reporting may be related to issues of empowerment and a sense of control.

According to Doerner and Lab (1998) older victims and parents of younger victims make a cost-benefit analysis of reporting. These individuals may assess the costs accruing from system participation as not being beneficial. It seems understandable that the victim, who has already received the first insult, would not voluntarily subject himself or herself to the second insult. Therefore, it is important for counselors to be aware of the possible reasons associated with regard to the victim reporting versus nonreporting as well as the outcomes of each and provide an environment in which disclosure occurs that is sensitive to the emotional capabilities of the child victim.

THE THEORIES OF CHILD MALTREATMENT

While the behavior of the perpetrator must not be excused, it is necessary for the helping profession to develop an understanding of possible underlying factors that lead to these behaviors. This understanding will aid in developing a more comprehensive view of the abuse and reduce chances of perpetrating a second insult on the victim. According to Azar (1991), two main forces influence model development regarding child sexual abuse and maltreatment, the legal profession and the medical profession.

The legal profession, according to Azar (1991), “views abuse as a criminal act and its epistemology fosters a focus on assigning blame and exacting retribution, not on searching for causes” (p. 31). Three areas identified by the legal profession in relation to child maltreatment include duty of care, civil liability, and criminal liability. Liang and Macfarlane (1999) summarized duty of care as “under the common law and statutes of most states, a parent has a legal duty to protect her child and do whatever may be necessary for that child’s care, maintenance, and preservation” (p. 406). Parents may be civilly liable for negligence when children are not protected from abuse (Liang & Macfarlane, 1999). Finally, According to Liang and Macfarlane (1999), “Parents can also be criminally prosecuted, under a number of different theories, for failing to protect their children from abuse” (p. 408). These theories are espoused in case law related to civil and criminal liability (e.g., Commonwealth v. Howard, 1979; Elliot v. Dickerson, 1992; Muehe v. State, 1995; Richie v. Richie, 1992; State v. Williquette, 1985).

The medical profession, according to Azar (1991), “drew on psychoanalytic thinking and employed intensive case studies in its search for causes” (p. 31). However, no strong empirical base of knowledge was developed from these cases. Some theories of child maltreatment include aspects of mental balance, sociocultural explanations, the possibility of the victim becoming the abuser, the ecological integrated model, and a developmental-ecological analysis.

According to Doerner and Lab (1998), one possible explanation that will lead to increased understanding of child maltreatment for the helping professional is the Intraintividual Theory. This approach views child maltreatment as the product of some internal defect or flaw inside the abuser. Although a child abuser is psychologically troubled, that psychopathological disturbance in an individual does not excuse the act of abuse. Treatment as an adjunct or additional consequence to incarceration is more acceptable than treatment alone. A crime has been committed and society will determine whether or not to allow the idea of mental imbalance to add to the second insult of the victim.

The second theory Doerner and Lab (1998) purport to explain child maltreatment is Sociocultural Explanations. This approach looks for events that are external to the individual. Stress found within the family, irritants such as unemployment, family size, and social isolation
are identified as some of the events that lead to
child abuse. However, when these stressors com-
bine it aggravates the situation. Families without
coping resources may then become frustrated,
feeling helpless over the situation. Unable to
control the situation, parents sometimes lash out
at children. Stress is a common and everyday
experience of life in this society. Throughout our
lives we have learned many ways in which to
cope with stressful situations without abusing
children, unfortunately this is not true for all
families. Utilizing Sociocultural explanations to
justify or explain away abusive behaviors would
only further the feelings of victimization and
self-blame of the child.

Rewarded activities, or those that go unpun-
ished sometime lead people to view their actions
as acceptable. Doerner and Lab (1998) identify
this explanation as the Social Learning
Approach. This theory takes into account the
entire family and the future of the family mem-
ers. There is a poem by an anonymous author
titled, “Children Learn What They Live.”
Relating this poem to the social learning theory
lends to the idea that if children experience
abuse and this abusive behavior is modeled as
normal behavior, the child will abuse later in life,
and thus, will perpetuate the cycle of violence.
The victim has the potential to become the per-
petrator. This cycle of violence is another form
of a second insult. Just as sexually abused chil-
dren are at risk for being more promiscuous later
in life, they too may be at risk for becoming a
perpetrator.

Belsky (1980) identified an ecological inte-
grated model of child abuse and neglect. This
model includes four potential causes of abuse
and neglect. First, Belsky (1980) stated the
childhood histories of abusive parents, or onto-
genic development, to be one part of the cause.
Second, the microsystem, according to Belsky
(1980), which includes “the family, the charac-
teristics of the abused child, the spousal relation-
ship, and sibling relationships” (p. 328) is anoth-
er cause for abuse and neglect. The final two
components are the exosystem (i.e., the neigh-
borhood, social support systems) and the
macrosystem (i.e., the culture). According to
Belsky (1980) when these systems interact with
each other in an unhealthy manner, the likely-
hood of child abuse increases.

In a developmental-ecological analysis,
Belsky (1993) purported that child maltreatment
occurs when an imbalance of supports or com-
pensary factors and stressors or potentiating fac-
tors exist. Belsky (1993) also related that causal
agents for child maltreatment are numerous. For
example, Belsky (1993) reported historical fac-
tors (e.g., social attitudes toward family privacy),
contemporaneous factors (e.g., poverty),
cultural factors such as a tolerance for violence
and situational factors such as crying episodes as
possible causal agents for child maltreatment.
Additionally, Belsky (1993) identified causal
agents related to parental attributes such as a
hostile personality and attributes of children
such as a difficult temperament.

While numerous models of the etiology of
child sexual abuse and maltreatment exist, no
single variable or factor and no one model is sat-
isfactory in accounting for significant levels of
abuse. Azar (1991) encourages the development
of models that denote the mediators between the
transactions and factors of abuse.

COUNSELORS AND
THE SECOND INSULT

According to Estes and Weiner (2001),
“Child sexual exploitation is the most hidden
form of child abuse in the U.S. and North
America today. It is the nation’s least recognized
epidemic” (2). In 1997, an estimated 3,195,000
children were reported to Child Protective
Service agencies as alleged victims of child mal-
treatment (Center on Child Abuse Prevention
Research, n.d.). The Center on Child Abuse
Prevention Research reported that the overall
total number of reports of victims of child mal-
treatment has increased 41% nationwide since
1988 and 1.7% from 1996 to 1997. Of these
cases, 15% included sexual abuse for both
reported and substantiated case (Center on Child
Abuse Prevention Research). In 1999, there were
estimated 826,000 child victims of maltreatment
within the United States, with the rate of victim-
ization 11.8 per 1,000 children (National
Clearinghouse on Child Abuse and Neglect,
As previously related, research indicates that numerous variables can lead to the retraumatization of the child victim. To aid in facilitating appropriate implementation of prevention and treatment interventions, health professionals may assess a number of risk factors for parents and children who are at risk for child maltreatment (Brown et al. 1998). Child sexual abuse is a risk factor for future sexual abuse. Observers attribute greater responsibility onto the victim as differences between the observer and the victim increase. Familial inability to help the young victim and a lack of reporting the crime can all lead to the retraumatization of the child victim. Further, when these variables interact with each other, an increase in the probability of retraumatization, the second insult, may occur. Implications for counselors include counselor competency and treatment, interviewing, collaboration between systems, and implementation of specialized programming.

Counselor Competency and Treatment

Those entrusted with the care of the child sexual abuse victim are encouraged be sensitive to the fact that their interventions, which are intended to be helpful, may actually retraumatize the victim. Child sexual abuse is a specialty area. According to Zuckerman (1995), if you are not experienced and trained, get consultation or refer clients before delving deeply into the topic. Lack of experience or training in this specialty area can lead to the contamination of the memories or interpretations. For example, the less a child remembers about the event the more the child can be misled, and the younger the child the less the child will remember (Zuckerman, 1995). Inappropriate treatment by an inexperienced professional, no matter how well intentioned, can result in more damage to the child sexual abuse victim and lead to retraumatization, the second insult.

King and Holden (1998) suggested counselors address not only intrapsychic and relationship issues, but also grief and multicultural issues. According to Hetherton and Beardsall (1988), cultural biases may lead to the retraumatization of the child sexual abuse victim. "The operation of a cultural bias specifically against women sexually abusing children is potentially most damaging when held by those who work in the initial stages of the child abuse continuum" (Hetherton & Beardsall, 1998, p. 1266). This cultural bias can lead to potentially devastating consequences such as believing their experiences are being trivialized. Children are very sensitive and aware of the feelings of those around them. Stereotypes and prejudices are not always easy for adults to conceal. Therefore, in order to avoid this second insult, it is incumbent upon those charged with helping child victims consider their own gender stereotypes and attitudes towards female perpetration as well as any prejudices or preconceived notions about victimization that may be harmful to the child victim.

According to Back and Lips (1998), many victims of abuse experience revictimization. The initial appraisal of responsibility is the key factor. Therefore, it is recommended during the initial stages of treatment that helping professionals complete an assessment of client’s perceptions of self-blame and guilt. Helping professionals can address these perceptions so as to normalize the child's feelings, while simultaneously countering maladaptive cognitions (Back & Lips, 1998). Further, helping professionals can reassure child victims that they are not responsible for their abuse as well as teach strategies for preventing further abuse within the cycle of violence. Helping to empower victims and teach them that they have some control over future abuse can help clients increase resiliency, and hence, increase the child victim’s feelings of power (Back & Lips, 1998). The helping professional’s sensitive and empathetic attention to the child victims' explanations as well as utilization of effective communication with the child victim will aid in the development of a better working relationship with the child victim, enabling young victims to better understand that they can guard themselves against future abusive situations. With especially young victims, it may be difficult or impossible to guard against future abuse without the inclusion of the family or appropriate caregivers. It is crucial, however, that the child victim clearly understands that
they are not responsible for the abuse that has already occurred. It is important that child victims free themselves from the notion that they had any responsibility for the crime that was committed against them.

The aim of counseling a child victim is multi-fold. First, sexually abused clients are likely to need assistance to move from the past so as not to become embedded in counter productive thoughts and feelings. Second, sexually abused clients are likely to need assistance in realizing that experience of future emotionally arousing stimuli, related to healthy sexual functioning, is not a return of the trauma. This will help reduce the incidences of reliving the trauma. Third, encourage and guide sexually abused clients to become engaged in the present and become capable of responding to current needs so as not to organize their lives around avoiding these experiences (van der Kolk, McFarlane, & van der Hart, 1996). "A sense of safety and predictability is a precondition for effective planning and goal-directed action" (p. 421). According to van der Hart, Brown, and van der Kolk (cited in van der Kolk et al., 1996), effective counseling treatment proceeds in phases. The first phase is stabilization. This includes education and identification of feelings. The second phase is the reduction or elimination of traumatic memories and responses. Controlled and predictable exposure to the traumatic memories can be useful. The third phase is the restructuring of traumatic personal schemas. Modification of one's view of self and others is highlighted in this phase. The fourth phase is the reestablishment of secure social connections and interpersonal efficacy. For young children, the family, if healthy, can usually assist in this reestablishment. The fifth phase is the building of healthy emotional experiences. Provide clients with consistent, positive, and healthy feelings about emotions and relationships. Talking about trauma is not enough. At times, taking some action that symbolizes their healing can be helpful to young victims. However, while helping a client go through these phases, the counselor is encouraged to remain aware of the possibility of retraumatizing the client.

**Interviewing**

According to Spaulding (1987), the interview process of a child victim is a significant factor in reducing the retraumatization of the child victim and aiding in identifying and prosecuting the alleged perpetrator. According to Spaulding (1987), effective interviewing of child victims can be achieved when the following steps are considered: "(1) Understand why specific techniques are used. (2) Create an environment comfortable for both interviewer and child victim. (3) Integrate informational objectives with legal requirements for use in court. (4) Acknowledge the needs of the child victim. (5) Continually evaluate yourself and your practices" (p. viii)." First, establish good communication and deal with the emotions of the child victim (Spaulding, 1987). Second, take into consideration the child victim's stage of development and the dynamics of the sexual exploitation. Further, emotional disturbance, such as anxiety can have a disruptive effect on the functioning of normal cognitions and intellect. According to Spaulding (1987), “When high anxiety is present, the investigator can expect the child to have difficulty in perceiving and remembering details and in recounting those details” (p. 7). Therefore, the investigator is encouraged to address these emotions to help facilitate a successful outcome. Finally, work to develop an understanding of how to effectively question the child victim and use tools, such as anatomical line drawings or anatomically detailed dolls, to elicit information (Spaulding, 1987). Further, Katz, Schonfeld, Carter, and Leventhal (1995) found that using anatomically detailed dolls strengthened the recall of children's memory regarding incidents of child sexual abuse. However, Aldridge (1998) found mixed and inconsistent support for the use of anatomically detailed dolls during interviewing and Bruck, Ceci, and Francoeur (2000) found commission errors among girls were more frequent when utilizing anatomically detailed dolls during interviewing. The use of anatomically detailed dolls is a tool and not an alternative to interviewing. “The objective of the interview is for the investigator to assist the child in verbalizing the
exploitation in a healthy way” (Spaulding, 1987, p. 17).

Grayson (1989) reported group treatment as the modality of choice when treating child victims. Group therapy provides support and reduces the child victim’s feelings of isolation. Dyad work, according to Grayson (1989) can also be beneficial if a child victim indicates interest in talking with another victim. Finally, family therapy is an important form of treatment according to Grayson (1989). This modality can be beneficial to both parents and victim in providing needed information and support. Further, Itzhaky and York (2001) advocate for an integrated program of intervention practices to contain and prevent child sexual abuse and Cnaan and Rothman (1995) advocate for group and other community subsystems.

Abused children are found in all socioeconomically, educational, ethnic, racial, and age groups. Sexually abused children may engage in excessive minimization and denial. Sadness, depression, and stress may lead to loneliness, fear, and a continual hopelessness that their situation will improve. Processing and facing the fears can eventually result in relief of trauma-related symptoms. Addressing these children’s beliefs about themselves, their low self-esteem, and their feelings of powerlessness is an appropriate role for counselors trained to work with child victims.

**Collaboration**

Mental health professionals such as counselors, social workers, and psychologists; medical professionals such as nurses and doctors; legal system professionals such as judges, prosecutors, and attorneys; as well as families are encouraged to be aware of the potential negative consequences their beliefs and actions can have on the child victim. A more collaborative approach to helping these young victims cope with the complexities they are facing can be beneficial (Keys, Bemak, Carpenter, & King-Sears, 1998). Further, Itzhaky and York (2001) advocate for “an integrated program of intervention practices to contain and prevent the incidence of child sexual abuse and incest” (p. 959). Implement guidelines for those entrusted with the duty to help. For example, recommend community centers offer facilities for workshops and meetings about child sexual abuse. Recommend preschool and elementary school personnel participate in workshops about child sexual abuse. Recommend parents attend workshops and meetings regarding child sexual abuse. Additionally, recommend community activists integrate information about child sexual abuse into daily meetings.

Treatment providers may benefit clients by adapting their services to match children's individual learning styles. Similar to the classroom, all children learn in different fashions. Children also respond to different styles of counseling. The counseling of child sexual abuse victims does not occur solely in a therapy room. According to Gray et al. (1999), treatment extends beyond the therapy room. If counselors involve educational personnel by working cooperatively with special education and school guidance professionals, children will have more opportunities to enhance prevention skills. "Educational programs targeted toward children, parents, teachers, law enforcement officials, judges, and physicians that highlight issues related to awareness, risk and protective factors, detection, treatment, and responsibility would also be useful in maximizing the prevention of child abuse” (Back & Lips, 1998, p. 1250). This type of educational programming would help reduce the potential negative consequences of the abuse.

However, counselors who work toward collaborative consultation may face some resistance to this process (Keys et al., 1998). For example, “Barriers to service provision were those that centered on the family – lack of motivation and cooperation, frequent moves, and not understanding the child’s needs” (Trupin, Tarico, Low, Jemelka, & McClellan, 1993, p. 804). These other systems have traditional ways of operating. It is recommended when introducing new or different approaches to aiding child abuse victims to include an educative base that will increase these systems' knowledge as well as their skills in working with child abuse victims. Systemic changes will help to ensure that services are
available and accessible to those that would benefit (Staudt, Scheuler-Whitaker, & Hinterlong, 2001). Further obstacles to service use include limited access to information about community services and an inability to gather information easily (Staudt, 1999). Education and consultation would lead to a more cohesive and cooperative interaction among the multiple systems that interact with the victim.

**Implementation of Specialized Programming**

Child sexual abuse can be one of the most complex and emotional problems that face the helping profession that includes additional knowledge regarding the legal process involved in child sexual abuse cases. Suggestions for helping professionals include being familiar with the mandatory reporting laws of their state. Helping professionals are legally bound to report any allegation or suspicion of child sexual abuse. A second suggestion for helping professionals includes training on appropriate ways to conduct an interview when child sexual abuse is suspected. It is suggested helping professionals be flexible in their approach and keep in mind the impact of the victim’s age, gender, ethnicity, abuse experience, and reaction of the people close to the child. Finally, it is suggested the helping professional, in order to be competent in working with children who are victims of child sexual abuse, secure sufficient and appropriate education and supervised experience in working with child victims. Courses at university counseling departments, workshops and continuing education, as well as supervision by experienced professionals in the area of child sexual abuse are recommended.

An integrated approach that specializes in working with child victims can reduce the occurrence of the second insult. This approach takes into account how to reduce the negative effects of the variables that lead to retraumatization. Counselors can use their skills as educators and advocates to help develop and implement a child-friendly place that is designed to respond more effectively to child sexual abuse.

Typically, the child victim goes from police stations and county jails, to the department of human services to busy hospitals and physician offices to the prosecuting attorney and then to the courts (Children’s Safety Center, n.d.). The child victim is questioned, examined, and questioned again and again. Many of the professionals the child victim encounters during this process, while well intentioned, are insufficiently trained or do not specialize in child sexual abuse. This process itself can lead to retraumatization of the child victim.

To better service child victims, mental health professionals can advocate for a comprehensive, child-focused program that will help prevent child victims from being retraumatized during the investigative process. This program would ideally include at least one professional from every agency involved in the process of investigating, treating, and prosecuting the case. Together, law enforcement, child protection professionals, doctors and nurses, and counselor and advocates can work together to ensure the needs of the child victim come first (Children’s Safety Center, n.d.). The advocate can also provide guidance and support during the legal process. For example, a representative from the local Victims Assistance program, which helps to guide and advocate for the victim participating in the legal system would be one such appropriate advocate. This program would ideally include an advocate for the child victim to ensure the rights of the child are protected. Next, the facility would ideally incorporate specialized medical equipment so that the exams can be conducted in a child-friendly environment that is quiet and non-threatening. Additionally, the medical exam can be videotaped as the child may reveal more information during the examination process. The interview process itself can be conducted in a comfortable, child-friendly room that includes a one-way mirror and videotaping. This type of provision would help to ensure that the child victim only has to relate the incident one time. Professionals from all the involved agencies can watch the interview behind the one-way mirror or by videotape. Further, counselors at this facility can provide the emotional support and treatment necessary. Information can also be made readily available to family members or caregivers about child sex-
ual abuse, and counselors can help to provide the ongoing treatment necessary to help prevent this abuse from reoccurring.

While, this type of facility is a rarity in today's society, progress has been made. For example, Child Protect, a Montgomery Alabama Area Children’s Advocacy Center, provides investigative services of children suspected to be victims of abuse in a child-friendly environment (Child Protect, Inc., 2002). At Child Protect, a Multidisciplinary Team works to minimize trauma to child victims of sexual and severe physical abuse with goals of preventing further trauma by eliminating multiple interviews, serving as an advocate for children and their families in court, and providing counseling for children (Child Protect, Inc., 2002). Additionally, facilities such as the Pueblo Child Advocacy Center and the National Children’s Advocacy Center in Huntsville Alabama provide similar intervention and treatment services to children (National Children's Advocacy Center, 2002; Pueblo Child Advocacy Center, 2002). Through educating those in the position to help, counselors can make great progress toward this type of child-focused center.

ILLUSTRATIVE CASE VIGNETTES

The intent of this article is to give an overview of the variables of retraumatization. Examples of how these variables affect the child victim would be helpful in developing a better understanding of retraumatization. The following case vignettes are based on first-hand experience by the authors.

The Case of Mary

Mary, a 20-year-old female, presented for counseling at the local mental health agency. She was having difficulty sleeping. Mary also reported having flashbacks related to a trauma that occurred earlier in her life. During the counseling process, Mary informed the counselor that her father had sexually abused her from a young age. Mary eventually summoned the strength to report her abuse to authorities. Mary's father was a very influential businessman in the community, was able to get the charges dismissed. To escape her father's abuse, Mary ran away. As Mary was a minor at that time she was picked up soon after by the police, charged with delinquency, and put on probation.

Mary is a victim of the first insult, child sexual abuse. She is also a victim of the second insult, consequences of reporting. The disclosure of her abuse did not benefit her. The charges were dismissed against the alleged perpetrator. When Mary tried to end her abuse by running away, the very system that she thought would help protect her labeled her a criminal.

The Case of Don

Don, a 15-year-old male, presented for counseling as a result of a court order. Don's paternal uncle raped him at the age of fourteen. However, he was not provided counseling at that time, as the family did not report the alleged rape. Don's family viewed the incident as a process of socialization and not a crime. Don was later brought for counseling after being convicted of raping a 9-year-old male. Don’s behavior is impulsive, exhibiting angry outbursts and a lack of empathy for others. Don’s father was physically and emotionally abusive toward the entire family and had been incarcerated for violence toward the family. Further, a neighbor raped Don’s sister and Don’s mother was reportedly abused in the past. Don’s family lacks social supports. In regard to the conviction of rape, Don’s mother blames the victim. She stated that the incident was only sexual exploration and does not consider the situation as a sexual offense.

Don is a victim of the first insult, child sexual abuse. He is also a victim of the second insult, consequences of family environment and the male as victim. Don’s family environment did not aid in his recovery from his initial abuse. The parents are illustrative of domestic violence and prior victimization themselves. The family did not utilize services that would aid in helping the family. Further, as Don is a male, his behavior and actions were not considered alarming, as Don’s mother believed that his activity was normal for boys his age. Therefore, Don was not
brought in for counseling voluntarily. As Don’s mother views her son’s behavior as normal as well as identifying the uncle’s interaction with her son as normal, she would benefit from information of sexually abusive youth and the cycle of violence.

The Case of Joe

Joe, a 12-year old male, was forced by his father to watch pornographic movies at a young age while his father raped him. When Joe was eight years old, a 14-year-old boy anally raped him. At the age of 10, Joe was hospitalized for aggressive behavior and suicidal ideation. Joe was brought into counseling after exposing himself to other boys, soliciting sexual acts from other boys, and committing oral sex on his 3-year-old brother. Joe victimized his female classmates by exposing himself to them and lifting up their dresses.

Joe is a victim of the first insult, child sexual abuse. He is also a victim of the second insult, consequences of prior sexual abuse, family environment, and male as victim. Joe was a victim of child sexual abuse by his father. The 14-year old boy revictimized Joe. This revictimization may be a possible consequence of prior sexual abuse. Further, Joe’s family environment was chaotic. The family environment had no social supports and included the use of drugs and alcohol in the home. Joe’s family environment did not lead to recovery, but to retraumatization. Finally, Joe exhibited many of the behavioral characteristics associated with child sexual abuse. Joe then became an abuser himself, a common fear of male victims (Grayson, 1998).

The Case of Ann

A 9-year old neighborhood boy sexually assaulted Ann, an 8-year-old female. Ann told her mother what occurred and was taken to the hospital. At the hospital, Ann received a physically intrusive examination. The doctor, nurse, and social worker questioned Ann about the incident. Ann was then taken to the police department and questioned by a police officer. A district attorney made Ann relate the incident again. The district attorney informed Ann’s mother that charges of rape would not be filed, as the incident was not considered rape due to the perpetrator’s age. Ann’s mother was infuriated by this decision and took Ann to an attorney to which Ann had to relate the incident again. The attorney recommended counseling for Ann and support for her mother. By the time Ann presented for counseling she was withdrawn, humiliated, and non-responsive.

Ann is a victim of the first insult, child sexual abuse. She is also a victim of the second insult, system abuse. If Ann had the opportunity to be treated by a facility like the one described in specialized programming she would not have had to repeatedly relate the incident. Additionally, someone trained to be sensitive to sexual assault would have performed her physical examination. Further, an advocate would have been able to provide information to the mother that would have explained the legal implications of sexual assault by another minor. Ann would have been in an environment that was more supportive and child-friendly. Her emotional needs would have been immediately addressed hopefully reducing the possibility of retraumatization.

SUMMARY

Cycles of depression, pervasive fear, a sense of self-blame, and an inability to trust self and others can occur in the victims of child sexual abuse. Frequently, there is a feeling of grave emptiness inside. As time progresses, affected individuals may find themselves participating in increasingly destructive behavior. Mental health professionals are encouraged to remember that each case of child sexual abuse is individual and familiarizing themselves with the variables related to retraumatization in order to educate and to intervene with clients where appropriate is beneficial in the reduction of the second insult. Mental health professionals can work to understand and counteract the high probability a victim has to being retraumatized. The victim is often blamed, lives in an environment that is dysfunctional, and is not protected. Reporting of sexual abuse brings with it additional concerns
and challenges that may be experienced negatively by the victim and may need addressed in treatment. There is no one correct way in which to treat child sexual abuse. However, there are numerous ways in which to retraumatize a child victim during the process of treatment and investigation.

Effective treatment goals for a child victim are achievable and directly related to the reason for referral. The safety of the child victim is a priority. Thus, treating professionals are encouraged to monitor the environment in which the child is exposed. The child victim needs to believe that they have the capability to deal with the trauma. Revealing information about the victimization is more beneficial when it is a gradual process so as not to retraumatize the child victim. A child-friendly environment in which all professionals involved in working with child sexual abuse can collaborate for the mutual benefit of the child victim is essential. Working toward emotional awareness of anger, fear, and guilt with the child victim through counseling is an ongoing process. First and foremost, however, the child is always the victim of the abuse, and there are no simple answers to explaining the causes of the abuse or the experiences of that child. Through greater awareness and understanding of the nature of abuse, and the potential consequences of reporting and seeking assistance, the professionals working with these victims will be able to reduce the possibility of experiencing the second insult. ◆

REFERENCES


Abstract: The purpose of this study was to evaluate the efficacy of a new method for treating psychological trauma called Trauma Relief Unlimited (T.R.U.). The method uses kinetic hand movements and nonverbal techniques. Forty adult participants were randomly assigned to either an experimental or control group. The control group was time lagged to receive treatment after the completion of treatment by the experimental group. Each participant received three 45 minute T.R.U. treatment sessions in a one month period. Participants were pre and post treatment tested with a four month follow-up using Briere’s Trauma Symptoms Inventory and client self report. Study results showed that T.R.U treatments significantly reduced symptoms of post traumatic stress at both post treatment and the four month follow-up period, with no adverse after-treatment effects.
A second historical approach has been cognitive therapy. The basic premise is that thoughts impact emotional states and by changing the thoughts one can alter the disturbing emotions. Theorists in this category include Beck (1976), Marks (1972), and Saigh and Bremner (1999) among others. Thus, disturbing, anxiety ridden, pathological emotional states are driven by dysfunctional thoughts. Cognitive therapy suggests that by changing the thoughts, the emotional states change. Cognitive therapy is used to provide a rationale for the victims to expose themselves to the pain of their experience. It is also used to reframe their perception of that experience and as a means of stopping dysfunctional thinking (Steele & Raider, 2001, p.11).

More recently, two other trauma relief methods have gained recognition. Drawing, or art therapy, has been used largely with children, although, more recently with adult trauma survivors. With children the rationale appears to be that they lack the intellectual ability to express themselves and particularly to express the emotions of disturbing events. Children draw their experiences and the therapist interprets them. This method seems to be a hybrid exposure and processing method. The exposure occurs through creative expression and the cognitive therapy occurs through interpretation of these drawings. Several authors have attested to the efficacy of this treatment including Byers (1996), Magwaza et al (1993), Malchiodi (1998, 2001), Pynoos and Eth (1985), and Steele and Raider (2001).

Another model, Eye Movement Desensitization and Reprocessing (EMDR), has also emerged. This, too, appears to be a hybrid model composed of both exposure and cognitive processing features. As Shapiro (1997) states: With EMDR we ask the person to think of the traumatic event, and then we stimulate the person’s information-processing system so that the traumatic experience can be appropriately processed, or ‘digested’. As this ‘digestive’ process takes place, insights arise, the verbal associations are made, whatever is useful is learned and the appropriate emotions take over (p. 29).

All of the above methods have had varying degrees of effectiveness and have undergone various amounts of scientific testing. The Trauma Relief Unlimited (T.R.U.) method was developed from Robert M. Cicione’s more than 20 years of experience as a psychotherapist and visual artist. Cicione was distressed at the amount of time needed to achieve results from the above methods and concerned with the painful negative side effects clients could experience from reliving the event. Wanting to integrate the revitalizing power of art to bolster the human spirit, Cicione began developing the T.R.U. method seven years ago. T.R.U. was derived from and shares common features with traditional art or drawing therapy, and it integrates other elements of the aforementioned methodologies. Informal data collection from Cicione’s private practice produced some of the first indications of T.R.U.’s effectiveness. Clients reported that PTSD symptoms were greatly reduced or eliminated with one to six T.R.U. treatments. Over 700 clients were treated with no or very slight, short term negative after effects such as mild fatigue or confusion. The T.R.U. treatment effects appeared to be unrelated to age, gender, or ethnicity.

In order to scientifically measure the efficacy of the T.R.U. method, a T.R.U. Pilot Project was conducted (Cicione, 2000). The pilot test used a pre-post treatment design with 10 trauma surviving children between 8 and 14 years of age. These multiple-episode survivors received three, forty-five minute T.R.U. treatments and were pre and post tested using Briere’s (1996) Trauma Symptoms Checklist for Children-Alternative Version (TSCC-A) and a Symptoms Tracking Form (STF) developed by Cicione. Trauma symptom scores were significantly lower (p<.01) at post test on three (anger, depression, and post-traumatic stress.) of the five TSCC-A scales. The decrease in the anxiety and dissociation scores was not significant. More importantly, TSCC-A scores continued to decline without further T.R.U. intervention to the point that all five TSCC-A scores were significantly lower (p<.05) at the four month follow-up.
in comparison to the pre-test levels. The STF collected frequency of client reported symptoms on a weekly basis. The total number of symptoms on the tracking form also fell markedly, from a mean of 8.58 per week pre-treatment to 0.4 per week after three sessions.

This research brief reports the results of the next phase of T.R.U. effectiveness assessment. The goals of this research study were three fold: (1) use an experimental and control group design with a larger sample; (2) measure the efficacy of T.R.U. with adults using a standardized trauma symptom instrument; and (3) assess the replicability of the method through the use of an independent therapist. It was hypothesized that T.R.U. would significantly reduce the symptoms of trauma in those treated and that these results would remain stable over time, regardless of who administered the treatment.

**METHODOLOGY**

**Intervention**

The T.R.U. treatment protocol consists of a series of kinetic exercises designed to activate the right hemisphere of the brain. The client is guided through a series of hand movements, using a 12”x 18” drawing pad and several multi-colored markers. Unlike traditional art or drawing therapy, the client is discouraged from drawing pictures. Cicione’s clinical experience indicates that adults experience performance anxiety when asked to draw. Therefore, drawing pictures is not part of the T.R.U. protocol. The process is designed as a non-verbal one. In fact, verbal expression during treatment is discouraged, since it has been found to lead to distraction from, and avoidance of, more significant ongoing, internal therapeutic processes. This non-verbal aspect of the treatment spares the client the need to verbally express disturbing emotional material sometimes leading to anxiety, emotional upset, flashbacks, vomiting or other regressive effects of other trauma treatments.

Unlike EMDR, there is no regression to “child self” experiences or distinctions made between adult and child self that may lead to further fragmentation. Also, unlike EMDR there is no left brain, internal processing like “interlooping or interweaving” (Parnell, 1997). Thus, T.R.U. is a very safe method with no reported cases of regression requiring emergency intervention, medication or hospitalization in over 2100 treatment sessions. The T.R.U. client is simply guided through a series of 12 to 15 “exercises” in a forty-five minute clinical protocol. Once complete, the symptoms are eliminated.

The utilization of T.R.U. as either a “stand alone” therapy or in conjunction with other clinical processes is determined by the nature of the situation and the discretion of the providing clinician. In multiple episode trauma situations T.R.U. is used to address traumatic material while other clinical processes may address other therapeutic issues. Since T.R.U. does not interfere with other therapeutic interventions, T.R.U. treatment may be received in conjunction with those therapies.

In single episode trauma situations the T.R.U. process may consist of an intake evaluation, one forty-five minute T.R.U. treatment and a summary evaluation, if necessary. In these situations T.R.U. may be seen as a “stand alone” treatment. This compressed T.R.U. process offers promise for treating major catastrophes requiring immediate brief intervention such as natural disasters, terrorist attacks and similar events where longer interventions may be restricted or even precluded. Ideally, the goal is brief, powerful, and effective intervention without sacrificing relatedness.

T.R.U. is a promising trauma relief intervention and not a panacea for all psychological and personal problems. Although effective in reducing common symptoms associated with post traumatic stress, T.R.U. has limitations. T.R.U. is not effective with alcohol or drug abusing clients, although it has shown promise for supporting the recovery process. T.R.U. is not usually effective with personality disorders, although in several instances trauma symptoms have been reduced while leaving the personality disorder largely unchanged. T.R.U. is usually ineffective with borderline patients, although improvement has been observed in some cases.

Although verbal expression during the
T.R.U. protocol is discouraged for the reasons stated above, there is verbal exchange with the clinician during the evaluation, debriefing and summary reporting parts of the process. Moreover, the clinician may use traditional talk therapy to address other issues such as lifestyle or relationships not directly related to trauma.

Participants

Participants were recruited through newspaper advertisements and professional referrals. To be eligible, they had to have experienced at least three episodes of trauma, have symptoms of post traumatic stress but no diagnosis of a major mental disorder or substance abuse, and be at least 18 years of age. Out of 61 applicants, 40 were eligible for the study and randomly assigned to an experimental group for immediate treatment or a one month delayed treatment control group. Of these recruits, two in fact had bipolar disorder and substance abuse was suspected in two others. Due to scheduling conflicts, 25 participants entered the immediate treatment group. Of the 15 in the delayed treatment group, three dropped out before receiving treatment, leaving a final N of 37 for statistical analysis. The average age was 44, with a range of 21 to 64. Of the 37 participants, 32 were women, 34 were white and three were black. Each participant received a 45 minute individual treatment session once a week for three weeks.

Instruments

Data collection instruments included the Trauma Symptoms Inventory (TSI) developed by Briere (1996) and a Symptoms Tracking Form (STF) developed by Cicione (2000). The TSI is a standardized 100 item self report questionnaire that measures post traumatic stress and related psychological symptomatology. It yields 10 clinical scales and three validity scales. A standard Trauma score (T-score) is calculated for each scale which can be compared to the Trauma scores of the participants in the instrument’s standardization sample. Trauma scores have a mean of 50 and standard deviation of 10. A score of 65 and higher is used as a clinically significant cut-off score.

The Symptom Tracking Form is a clinician interview form developed to measure the weekly frequency of specific post traumatic stress symptoms such as violent episodes, angry outbursts, nightmares, flashbacks, anxiety symptoms, and crying episodes. Clinicians also rated the participants’ level of depression on a six point scale with 0 being no depression and 5 being a high level.

Data Collection

Both the experimental and the control group completed the TSI and STF at all data collection points. The experimental group participants were pretested as they came into the study, received three 45 minute weekly treatment sessions, and then post-tested at two weeks and at four months after their last counseling session. The control group participants were pretested at entry into the study and post tested four weeks later without any intervention. They then received three 45 minute weekly treatment sessions and were post tested at two weeks and at four months after their last session.

In order to assess possible experimenter bias, two clinicians conducted the interventions with the experimental group: the founder, an LICSW clinician and artist, and an LICSW clinician with 10 years of professional experience, but not in the field of trauma or art. The second clinician received eight 45 minute pre-study training sessions with the founder.

Analytic Procedures

All statistical analyses were conducted using t-tests. Standardized TSI scale scores were calculated and compared between experimental and control groups at baseline, and at post test 1. The two groups were then combined for a larger N of 37 and comparisons were made between pretreatment and follow-up scores, between posttreatment and follow-up scores, and between posttest and follow-up scores. The mean number of reported symptoms from the STF was analyzed for the same time points and by clinician.
Table 1. Pre-treatment Trauma Scores for TSI Clinical Symptoms by group

<table>
<thead>
<tr>
<th>TSI Scale Item</th>
<th>Experimental Group Pre treatment</th>
<th>Control Group Pretest</th>
<th>n=15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>pretest Mean (std dev)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxious Arousal</td>
<td>66.04 (10.47)</td>
<td>67.73 (5.82)</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>62.80 (10.30)</td>
<td>70.82 (5.40)</td>
<td></td>
</tr>
<tr>
<td>Anger/Irritability</td>
<td>58.28 (10.57)</td>
<td>62.36 (7.83)</td>
<td></td>
</tr>
<tr>
<td>Intrusive Experiences</td>
<td>66.24 (11.99)</td>
<td>67.73 (9.70)</td>
<td></td>
</tr>
<tr>
<td>Defensive Avoidance</td>
<td>63.56 (11.00)</td>
<td>62.82 (8.60)</td>
<td></td>
</tr>
<tr>
<td>Dissociation</td>
<td>64.40 (11.43)</td>
<td>68.18 (7.86)</td>
<td></td>
</tr>
<tr>
<td>Sexual Concerns</td>
<td>61.88 (14.75)</td>
<td>54.45 (6.25)</td>
<td></td>
</tr>
<tr>
<td>Dysfunctional Sexual Behavior</td>
<td>58.76 (17.03)</td>
<td>51.18 (5.98)</td>
<td></td>
</tr>
<tr>
<td>Impaired Self-reference</td>
<td>64.88 (10.43)</td>
<td>61.55 (5.50)</td>
<td></td>
</tr>
<tr>
<td>Tension Reduction Behavior</td>
<td>58.12 (14.60)</td>
<td>56.18 (5.10)</td>
<td></td>
</tr>
</tbody>
</table>

*No significant differences occurred between groups

(left) **Figure 1.** Comparison of Trauma Symptom Inventory T-scores for control group baseline clinical scales

- Baseline before Wait period
- Baseline after Wait period

*No Significant Difference between Baseline Measurements*
RESULTS

Trauma Symptoms Inventory

No significant differences occurred in the scores of the experimental and control groups at baseline on the TSI. See Table 1. Figure 1 indicates no significant change occurred between the pre and post test scores for the control group as well.

As Table 2 indicates, a significant reduction (p<.01) occurred in the clinical symptoms on all 10 of the TSI clinical scales between pretest and posttest, confirming the hypothesis that T.R.U.
Participants’ scores were in the clinically higher than normal range (>=65) on four of the TSI scales (anxious arousal, depression, intrusive experiences and dissociation), but all scores were within normal range at post-test and at follow-up. Scores remained stable at the four month follow-up, with all trauma scores remaining significantly reduced from their pre-test level.

**Symptom Tracking Form**

Results from the Symptoms Tracking Form indicate scores decreased on all measures (see Table 3). Significant decreases (p<.01) occurred on three of the seven symptom ratings (flashbacks, anxiety, and depression) at both post-test and follow-up. The mean number of symptoms consistently dropped on all measures between post treatment and follow-up.

**Clinician Comparisons**

In the comparison of clinician interventions, the T.R.U. founder (clinician 1) treated 15 clients and clinician 2 treated 10 clients in the experimental group. The T.R.U. founder subsequently provided treatment to all the clients in the control group. The participant numbers were too small to reliably analyze the results of the TSI scores between the two clinicians. On the STF the frequency of self-reported symptoms was near zero at posttest for participants of both clinicians. Figure 2 illustrates the frequency of flashbacks reported to the two clinicians.

### Table 3. Pre and Post Treatment Scores for Self-Reported Symptoms

<table>
<thead>
<tr>
<th>Trauma Symptom</th>
<th>Pre-Treatment Mean</th>
<th>s.d.</th>
<th>Post-Treatment Mean</th>
<th>s.d.</th>
<th>t-value pre-post test</th>
<th>Follow-up Mean</th>
<th>s.d.</th>
<th>t-value pretest-follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence</td>
<td>.32</td>
<td>1.19</td>
<td>0</td>
<td>1.63</td>
<td>0</td>
<td>1.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td>-</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nightmares</td>
<td>1.55</td>
<td>1.91</td>
<td>.74</td>
<td>1.59</td>
<td>1.97</td>
<td>.69</td>
<td>1.79</td>
<td>1.92</td>
</tr>
<tr>
<td>Flashbacks</td>
<td>10.69</td>
<td>19.14</td>
<td>.70</td>
<td>2.38</td>
<td>3.15**</td>
<td>.44</td>
<td>2.47</td>
<td>3.22**</td>
</tr>
<tr>
<td>Anxiety</td>
<td>4.81</td>
<td>6.89</td>
<td>1.14</td>
<td>3.57</td>
<td>2.88**</td>
<td>.45</td>
<td>1.36</td>
<td>3.76**</td>
</tr>
<tr>
<td>Crying</td>
<td>2.73</td>
<td>8.17</td>
<td>.78</td>
<td>1.49</td>
<td>1.42</td>
<td>.28</td>
<td>.68</td>
<td>1.81</td>
</tr>
<tr>
<td>Depression</td>
<td>3.30</td>
<td>1.43</td>
<td>1.32</td>
<td>1.43</td>
<td>5.92**</td>
<td>.91</td>
<td>1.20</td>
<td>7.45**</td>
</tr>
</tbody>
</table>

N=37 ** p< .01
DISCUSSION

The Trauma Relief Unlimited brief intervention method shows promising results that demonstrate reduction or elimination of trauma symptoms without reoccurrence. It is a cost effective method that can be easily taught to other trained professionals who have little experience counseling trauma survivors. It has few, if any, negative side effects. Preliminary findings suggest that it works without regard to the severity of the symptoms expressed. Even the two participants with diagnoses of bipolar disorder who were allowed into the study demonstrated greatly reduced trauma symptomatology. Current understanding of brain functioning is not sufficiently developed to explain why the method works. Ongoing neurobiological research may better explain the dynamics of its effectiveness. Future articles and research will address in greater detail the similarities and differences of the T.R.U. method to current psychological theory and practice (Cicione, in preparation).

The current research project was limited by small numbers of participants who were self-recruited through newspaper advertising. Random assignment to groups was hindered by scheduling conflicts and potential loss of an additional five participants if not scheduled for the experimental group. Larger numbers of participants would also have permitted more sophisticated statistical analyses and comparisons. Recommendations for future research on T.R.U. are as follows: Replicate the current study; increase sample size; particularly when using more than one therapist to administer the method; increase the diversity of the sample.
demographically and for diagnostic categories; utilize instruments that measure the neurobiological impact of trauma and are sensitive to changes over time; extend the follow-up period to at least two years post test with quarterly or triennial data collection; and compare the effectiveness of T.R.U. to other trauma intervention methods. Such research will provide us with a better scientific understanding of the capabilities of the T.R.U. method and its long term effectiveness. The ultimate goal is to provide proven, research-based interventions to trauma survivors.◆

REFERENCES


Cicione, R.M. (in process). A Comparative discussion of the Trauma Relief Unlimited treatment intervention with other trauma methodologies.


Abstract: Research documenting the effects of trauma on learning and behavior has become increasingly available and consistent in its descriptions of the cognitive and behavioral alterations following exposure to trauma. From early infancy through adulthood, trauma can alter the way we view ourselves, the world around us, and alter how we process information and the way we behave and respond to our environment. Without intervention these cognitive processes and behavioral responses can lead to learning deficiencies, performance problems, and problematic behavior. School systems need to be encouraged to provide trauma-specific intervention to its traumatized students to help minimize the learning and behavioral difficulties that can result when the needs of trauma victims go unrecognized or ignored. To appreciate the preventative need for structured trauma-specific intervention following critical incidents, one must understand the functions of the brain in the midst of trauma.

Following exposure to a potentially trauma-inducing incident, survivors may become frozen in an activated state of arousal. Arousal refers to a heightened state of alert or a persistent fear for ones safety. Short-term and prolonged arousal can effect cognitive and behavioral functions. In the arousal state, changes in the brain are triggered by a variety of stress related functions (van der Kolk, 1996). Bremmer et al. (1996) found that victims of physical /sexual abuse traumatization had lower memory volume in the left-brain (Hippocampal) area than did the non-abused. This left-brain function refers to understanding or processing information. One of these functional alterations takes place in the neocortex. Perry (2000) and others have found that while in the arousal state it becomes difficult to process information because of the altered functioning of the neocortex. Anyone who has had to see a physician for potentially life-threatening condition may remember very little of what the physician says. Only after getting home, (a place of safety) comes the realization of how many questions needed to be asked, which were forgotten at the time. Health advocates today, understand how difficult it is for a patient to process information while in a anxious (arousal) state and recommend that patients take another family member or friend with them to the doctors office as well as write down all the questions needing to be asked.

If a child/student who has been traumatized remains in an aroused state of fear and finds it difficult to process verbal information it then becomes difficult to follow directions, to recall what was heard, to make sense out of what is being said. Focusing, attending, retaining and recalling verbal information becomes very difficult. These are primary learning functions that can be altered during or immediately following traumatic exposure and for some continue unrecognized for long periods.

William Steele, MSW. PsyD is the Founder and Director of The National Institute for Trauma and Loss in Children. He is author of numerous books, articles, interventions and videos. He is a consultant to schools and agencies across the country and a frequently requested presenter in the area of children and trauma.
Cognitive deficits such as poor problem solving, (unable to think things out or make sense of what is happening), low self-esteem (how one thinks of oneself – victim-thinking) and hopelessness (loss of future orientation) have all been clearly linked to negative (traumatic) life events (Yang and Clum, 2000). The fact is, trauma has been shown to significantly compromise cognitive development (Trickett, McBride, and Chang, 1995). Yang and Clum (2000) using a series of structured equation analyses showed that “early negative life events” have a strong impact on cognitive deficits, which are now related to have a strong impact on suicidal behavior as well (183). Furthermore, stress induces the release of glucocorticoids, such as cortisol, that can damage the left Hippocampal area of the brain, increasing memory deficit.

Cognitive alterations following trauma can take place at any age including early infancy. The right brain is involved “in the vital functions that support survival and enable the organism to cope actively and passively with stress (Schore, 2001, p. 41).” “The right hemisphere controls perception analysis of visual patterns,.... and emotions (Alessi & Ballard, 2001, p. 398). Buck (1994) supports the belief that the right brain is where the dominant reactions to stress occur. Main (1996) observes that the ability to regulate one's response to stress can be negatively altered even during early infancy when a child is exposed to such negative environmental influences as violence. Schore (2001) concurs and Hopkins and Butterworth (1990) support these and similar findings that appropriate responses to external changes (stress/crisis) can be altered by activation of the arousal state – the heightened state of fear induced by traumatic exposure.

Following the September 11, 2001 attack on America, millions in this country experienced the absence of a sense of safety and, as a result, thought processes were immediately altered. Unlike the tragedy and massacre at Columbine High School, parents across the country rushed to school to be with their children, or to take them home. Their thoughts and behavior reflected fear, terror, a sense of powerlessness, confusion; the inability to think clearly, to process all the information. For a brief moment, Americans experienced to some degree immediate arousal. No matter what was said (cognitive) people no longer felt safe. Cognitive processes were significantly altered.

At some point, trauma victims must begin or have help to think differently about what they experienced, how they view themselves and the world. For many trauma victims, increased arousal keeps them frozen, thinking as a “victim:”— powerless, hopeless, under constant threat. The reduction of arousal is essential to the restoration of these functions. Such intervention can be applied in school settings the days and weeks following trauma-inducing critical incidents, which impact school students and staff. Interventions must help trauma victims become trauma survivors by helping them to change their thought processes. However, cognitive intervention can only be successful when first the sensory experience to trauma is altered. Following September 11th, for example, Americans were repeatedly reassured (cognitively) they were safe, but this could not be accepted until they first felt safe — a sensory experience. Parents who saw uniformed police officers in the parking lot when they arrived at their child’s school, felt safer than those who saw no visible sign of safety. What was seen communicated a greater sense of safety than what was being heard. Understanding trauma as a sensory experience is also critical to understanding the levels of intervention necessary to restore cognitive functioning as well as behavioral appropriateness.

SENSORY FUNCTIONS – BEHAVIORAL RESPONSES

We have learned that while in the arousal state or, not feeling safe at the sensory level, cognitive functioning and processing is altered. Short-term memory suffers (Staknum, Gebarskie, Berent, and Schfeingart, 1992); verbal memory (explicit) also decreases (Bremmer, 1995). Behavior is in response to what is sensed. Aggression, agitation, exaggerated withdraw, loss of small motor activities; like being unable to unlock a door, make a phone call, unable to talk (stuttering), unable to sleep, are not uncommon behaviors in response to trauma (Le Doux,
Romanski, and Xagoraris, 1991). Children can be easily startled and become behaviorally reactive to perceived threats. A study on children’s recall following a horrific earthquake found that 90% remembered the earthquake, but their memory was very selective and related to events that had personal meaning for them (Azarian, Lipsett, Miller, and Skripchenko-Gregorean, 1999). If that meaning involves a sensory (felt) threat, real or perceived, behavior changes accordingly. Even though the danger may be over the “sense” that it is not can lead children, for example, into being fearful of leaving home. Behavioral changes in addition to the alterations of cognitive processes discussed earlier are often misread for resistance, stubbornness, over reactivity, impulsiveness, confrontational or a having a learning disability or Attention Deficit Hyperactive Disorder (ADHD) (ADHD Report, 2000).

As a sensory experience trauma is encoded in the implicit memory (right-brain area). Implicit memory also referred to as “procedural memory” refers to how an event is remembered by the body and central nervous system (van der Kolk, et al 1996; Squire, 1994; Rothchild, 2000). The trauma experience is stored implicitly via images, sensations, affective and behavioral states. Although in the early days following the Attack on America, Americans were repeatedly reassured of their safety by the President, The Wall Street Journal (date unknown) reported that for several weeks the consumption of mashed potatoes had significantly increased. In other words, it was comfort food (a sensory experience) that brought some relief. In the midst of trauma, and for some, following their traumatic experience cognitive reassurances, attempts to appeal to our “explicit” or “declarative” memory simply is not enough. At the sensory level what we see, what we “sense” becomes far more important to survival than verbal information. Telling parents their children were safe at school was not enough on September 11, 2001; parents needed to be with their children and to “see for themselves” that they were safe.

**BEHAVIOR**

This “sensory state” of trauma is defined by a sense of terror, powerlessness, and the absence of a sense of safety. In this sensory state, behavior is altered in response to the danger we sense. Well-trained and knowledgeable educators on September 11th left television sets on all-day in elementary classrooms across the country. In their panic and terrifying alarm, they lost sight of the undue exposure they inadvertently provided their students. Weeks later, when some sense of safety was returned, the very same educators reported they now realized that, in their own panic, they left the children unprotected and over exposed; they weren’t thinking clearly at the time. They were functioning at a sensory level, not a cognitive level.

van der Kolk, (1994); Levine, (1997); Saigh, (1999) have supported that trauma is experienced as a sensory experience and only later ordered as a cognitive experience. Another way to state this is that students who do not feel safe, find it difficult to learn; they even find it difficult to remember (Matthews and Saywitz, 1992) and, while in an aroused state, begin to behave in ways that are problematic. Not until a “sense of safety” is returned are cognitive processes restored, behaviors returned to pre-trauma level. The questions this presents, therefore, are what type of intervention can best restore this sense of safety (decrease arousal); how soon can we intervene and can these interventions be provided in the school setting?

**TRAUMA INTERVENTION**

As detailed earlier, trauma can trigger (arouse) the activation of the autonomic nervous system to ready itself to resist or solve the real or perceived threat presented by exposure to a critical incident (van der Kolk, et al 1996). If the response (arousal) is not discharged or deactivated, the sustained arousal state can lead to sustained cognitive and behavioral dysfunction (Grill, 2001). Trauma being a sensory experience (Lang, 1979; Steele, & Raider, 2001; Rothchild, 2000), arousal is experienced as an absence of the “sense of safety” and as a “sense of power-
lessness.” Aggressiveness, over reactive responses and exaggerated withdrawal (Le Doux, Romanski, & Xagoraris, 1991) are survival behaviors – attempts to feel safe, in control. As long as a child is not feeling safe and in control, this aroused state makes it difficult to process verbal information, attend, focus, retain and recall (Perry, 2000, Starknum, Gergarski, Berent, & Schteingart, 1992; Saigh, 1999). Intervention designed to deactivate the arousal state and return the child to a sense of safety and a sense of power or control, helps to restore previous cognitive and behavioral patterns (Thompson, Charlton, Kerry et al. 1995). The most immediate, short-term and long-term intervention, therefore, must be designed to restore that sense of safety and power.

FOUR LEVELS OF INTERVENTION

It is important to understand that not all students/staff exposed to a critical incident will need all four levels of intervention. Not all students/staff will experience a critical incident with the same level of vulnerability. Some victims will feel safer and more in control than others. Some will perform better at a cognitive level than others. To pull all students, or all staff for example into debriefing (second level of intervention) may needlessly overexpose some of the participants and worsen their original reactions (Mc Farlane, 1994).

We must, therefore, be careful to apply the least intense and least intrusive interventions first (Rando, 1993). The National Institute for Trauma and Loss in Children (TLC) approaches trauma intervention at four different levels. Level one – crisis intervention, level two – debriefing, level three – social responsiveness, and level four – structured sensory intervention. These interventions are detailed in TLC’s Trauma Response Protocol Manual, Debriefing Handbook for Schools and Agencies, Structured Sensory Interventions for Children, Adolescents and Parents (SITCAP), and Schools Response to Terrorism: A Handbook of Protocols. This format only allows us to identify the key elements of these four levels of intervention which help to deactivate the state of arousal or restore a sense of safety and power (control) as quickly as possible.

LEVEL ONE - CRISIS INTERVENTION

The value of crisis intervention was established as early as 1944 by Eric Lindemann (1944), who detailed the grief reactions of those involved in the Cocoanut Grove fire in Boston. Hundreds of books and research projects have since detailed its benefits for children and families (Caplan, 1964; Rapoport, 1970; Johnson, 1993; Webb, 1994). Schools became familiar with the importance and need for crisis intervention in the early 80’s when suicide among children became an epidemic. Most schools today have, in place, a set of protocols to initiate when a critical incident takes place. Some, of course, are more comprehensive, more practical, and more user-friendly than others. TLC’s Trauma Response Protocol Manual (Steele, et. al 2000) was developed with the help of some 1,500 school professionals across the country who had first-hand experiences with critical incidents. It is written in a format that details specific tasks needed following those situations.

What is most important concerning the types of crisis intervention initiated is that it directs itself to restoring a sense of safety and control, for all students and staff. Crisis intervention is the first level of intervention. It is initiated immediately following a critical incident and continues for two-to-three days. It consists of organized responses (protocols), dissemination of information, in part through classroom presentations and, attending to the emotional needs of those involved.

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How important is it to have an organized protocol? We have learned that in the midst of trauma normal cognitive functions can be overwhelmed and disappear because of the sensory nature of trauma. Hundreds of examples exist which show that otherwise calm, organized staff lose their ability to think clearly in the midst of trauma. In a sense, protocols exist so people don’t have to think in the midst of chaos, yet still act appropriately. Protocols, in other words, are the result of an orderly “thinking things through” before they happen, so that appropriate actions
are immediate. “A time of crisis is not conducive to improvisation. Prior preparation and orientation of staff members regarding management of a crisis will greatly assist those expected to assume leadership roles and, initiate actions appropriate to the time of need” (Webb, 1986, 476).

This following scenario illustrates the need to have protocol that are designed to keep everyone safe, regardless of their ability at the time to think clearly. Imagine a school building under attack. Panic sets in: some freeze, some flee, and some stand ready to fight. Those who freeze or run in terror will find it very difficult to take verbal directions. They need to first see someone they recognize and then either be physically led or guided to a predesignated area of safety. This tells us that we must have personnel in that school who are clearly identifiable (staff identification badges) and who position themselves as visible reference points for those in panic to run to and then be directed to a predesignated safe area. There will also be a need to physically assist those who freeze and are unable to move into that safe area. Those certified by TLC understand that the use of personnel in this fashion address sensory reactions in the midst of trauma versus basic cognitive functions which may not be accessible to many at the time of the trauma. Many elementary teachers across the country left television sets turned on the day of the 9/11 terrorist attacks. We cited the example earlier that adults had a need to know what was going on in order to try and manage their anxiety. However, they unduly over-exposed the children. Weeks later, when feeling safe, most were able to cognitively understand that they had not afforded their children protection from overexposure. They also now understood, that in the midst of trauma, we do not always, cannot always, rely on cognitive processes to assist us. These same teachers will act differently the next time because of what they have learned.

Organized protocols, therefore, help support the deficiencies in cognitive functioning that can occur in the midst of trauma.

**AUTHORITY – INFORMATION**

Imagine being in a surgical waiting room. The doctor tells you he/she will be out at 3:00PM to let you know how your loved one is doing. It is now 3:05PM. You begin to think the worst has happened. What you need more than anything else is a person in authority (the doctor in this case) presenting information to calm and reassure you. In school settings it is critical that students, staff, and parents hear from someone in authority – the principal/superintendent. It is important that factual information be presented and reassurance given that the school is prepared, and its staff trained to manage these situations. Classroom presentations in the first two days accomplishes this element of crisis information.

Keep in mind that not everyone can process all the information presented during those initial days. However, for many, information is what lowers their arousal (anxiety, fear) and restores their sense of safety. The important issue related to classroom presentations is that all students are given the same presentation and information. If each group hears something different it only creates confusion as students begin to talk to one another about what they were told. For this reason TLC has a classroom presentation model that it encourages all presenters follow. This maintains the orderly response so critical in the first few days. This process also allows students and staff the opportunity to develop a uniform, cognitive understanding of what has happened as well as be prepared for what will be happening the remainder of that day and the days that follow.

**EMOTIONAL NEEDS**

For many, no additional intervention will be needed. However, some will need additional crisis intervention to attend to their emotional reactions. Listening, attending, acknowledging, summarizing, reflecting, normalizing, nurturing, correcting false information, planning for the remainder of the day, the evening, empathetic responses are the primary crisis responses at this time. This type of special attention, for those
having a difficult time emotionally, often is all that is needed.

**LEVEL TWO – DEBRIEFING**

In research evaluating the outcome differences between those exposed to debriefing and those not involved in debriefing, those groups who participated in debriefing reported having shorter duration of reactions and less intense reactions. Debriefing can accelerate symptom reduction (Hokanson & Wirth, 2000; Everly & Mitchell, 2000; Eid., Johnson, & Weisaeth, 2001). Dr. Jeffery Mitchell, a former fireman, is credited with establishing the Critical Incident Stress Debriefing Model and process designed to assist rescue workers and survivors of catastrophic situations. Other models have been developed: Armstrong, et. al (1991), Raphael (1986), Hobfoll (1994), but Mitchell’s model receives the most attention.

The purpose of debriefing is to give participants the opportunity to tell their story by using very focused questions that identify the cognitive, affective and behavioral experiences of the participants. The formal debriefing model is, however, very cognitive and its processes do not address the unique needs of schools and students. The National Institute for Trauma and Loss in Children, with the help of some 1,500 professionals across the country developed several models to meet the needs of the various ages of students; the needs of the most exposed and least exposed, the needs of staff and of administrative response. Trauma Debriefing for Schools and Agencies (Steele, 1999) is now used in schools across the country. Defusing for younger children, debriefing for adolescents and adults, operational debriefing for all staff and debriefing crisis teams are the major models used by TLC. Debriefing is only for the most exposed and takes place in most situations about the third or forth day following the incident.

In New York following 9/11 over 8,000 students were evacuated from the target area and relocated to other schools and sites (Lehmuller & Switzer, 2002). Because of all that was actually happening, debriefing was not a possibility for several days. In situations where major everyday functions or resources cease like electricity, or water supply, inaccessible roads, etc. the initiation of debriefing may not occur until these services and resources are returned.

**EXPOSURE**

Not everyone will need debriefing. Debriefing is generally reserved for the most exposed. There are four possible ways to be exposed, 1) as a surviving victim – victim of physical/sexual abuse, other assaults, community violence, critical injuries, catastrophic situations, etc., 2) as a witness to any potential trauma-inducing incident; violent or non-violent – murder, suicide, assault, car fatality, bus tragedy, house fire, drowning, etc., 3) being related to the victim – as a family member friend, or peer. (“Being related” can also include one’s perceived similarity to or personal identification with victims. Milgram and associates (1988) found in their study of 268 seventh graders following a tragic school bus accident that “personal involvement” with the victims, rather than the incident itself, increased the level of prevalence. A study of 64 children (Schwarz & Kowalski, 1991) following a school shooting showed that irrespective of physical nearness to the event, emotional stress resulting from personal identification also led to Posttraumatic Stress Disorder (PTSD); 4) Verbal exposure – Saigh (1991) found that listening to the details of traumatic experiences, traumatic stress reactions can be induced. This is especially true for professionals responsible for intervention with traumatized children. Vicarious traumatization is always a potential development. Children who are exposed to repeated media coverage of details and survivors, understandably still may be vulnerable to trauma reactions.

Being “related to” and a “witness to” is far more frequent in today’s technological society. Approximately six months after the Oklahoma City bombing this author was speaking to a group of Head Start teachers. During the presentation, one of the teachers told the story of how her children spontaneously devised a game where one half of them took all their sleeping (floor) mats and covered themselves. The other
half, in pairs of two, one at a time would go over
to the other children, lift up the mat, picked up
the child under the mat and then escort that child
over to the other side of the room by their indoor
soccer nets. They did this until all of the children
under the mats were rescued and taken to the
“safety” nets. Afterward, they switched sides. Rescuers became victims trapped under the
mats; victims were now rescuers.

By being witnesses to the tragedies of the
bombing and seeing the rescue workers carry out
children their own ages from the rubble of their
day care center, these children identified with the
victims and consequently needed to find a way
to conquer the fear induced by being witnesses
and recovery themselves to be “related to” the
victims.

Debriefing is unlike any counseling process.
Training is necessary to learn how to conduct
debriefing. In school settings, debriefing should
only be conducted by trained social workers,
counselors with experience in working with the
age level of those being debriefed and who also
have a working knowledge of the developmental
issues at the various age levels. Debriefing six-
year-old children is far different than debriefing
sixteen-year-old adolescents.

LEVEL THREE –
SOCIAL RESPONSIVENESS AND
EMPOWERMENT

Level three is not a formal intervention for
persistent reactions, but is actually happening
concurrently with debriefing. It applies itself to
the general population who needs to do some-
thing to feel better.

These intervention activities are sometimes
spontaneous and can be initiated by staff or stu-
dents. In most cases, they begin three or four
days following the critical incident, but can
begin earlier. They are sensory in nature, in that
participants are actively involved in doing some-
ting in response to the trauma experienced.
Following 9/11, for example, blood drives were
initiated, monies were collected, letters written,
pictures drawn that were then sent to victim’s
families and students in the attack area, vigils
were held, community forums addressing cultur-
al and religious issues triggered by the attack
were convened, the meaning of such an attack
were discussed in social science and history
classes.

It is this kind of social response at a sensory
level that helps to return a sense of control and
power to those who were left feeling vulnerable
following exposure. They can help to empower
not just individual students or staff, but an entire
community. They also provide the opportunity to
teach children about the value of life, respect for
diversity, generosity of spirit, care for others, and
how to collaboratively work together to support
one another in a time of crisis. They generate a
social conscience as well as help teach children
difficult lessons. They also help restore a sense
of hope.

Numerous activities were encouraged and
supported by the US Department of Education,
Parent Teacher Associations, American
Psychological Association, National Association
of School Social Workers, Educators for Social
Responsibility, American Academy of Child and
Adolescent Psychiatry, National Institute of
Mental Health, National Institute for Trauma and
Loss in Children, and many other state and local
organizations. Schools Response to Terrorism: A
Handbook of Protocols, published by TLC (Fall,
2002) provides a wide-range of social responsive
and empowerment activities and resources.

Research related to the value of such activi-
ties is limited, yet administrators across the
country saw how such activities had value in not
only giving their students a voice, but in helping
them collectively feel better. They become a way
to help the “negativity” and “impotence” sur-
vivors can be left with immediately following
exposure (Rowlands, 1998). They help children
“gain control of the intense emotions and sense
of helplessness that follow community disaster”
(Austin, 1992). For immediate survivors, the
outpouring of support helps to “validate” the
value of the sacrifices made by their loved ones
(van der Kolk, 1996).

This article does not permit a full discussion
on memorial services within school settings,
which is a level three intervention. The National
Institute for Trauma and Loss in Children recom-
mands that memorial services not be conducted
in school settings, especially following a suicide because of the risk of contagion (Phillips & Carstensen, 1986; Gould & Schaffer, 1986). If one understands the nature of trauma, one understands that prolonged exposure via physical proximity to memories of the deceased can leave survivors “frozen” in their grief and trauma. This was the primary reason, that administrators decided to build an entirely new library for Columbine High School (Semas, 2001). (Additional protocol following student deaths can be found in Trauma Response Protocol Manual and activities for students following terrorism or when multiple deaths occur can be found in Schools Response to Terrorism: A Handbook of Protocols (Steele, Brohl, N. and Brohl, P. 2002).

The social aspect of this level of intervention may not help individuals with more intense or severe levels of trauma reactions. For some, it may even delay reactions. Think in terms of rescue workers, who work hard at doing what they are trained to do. When all of the activity ceases, the reality of what they have been exposed begins to take hold and reactions emerge. For some of these rescue workers, additional intervention will be needed.

**LEVEL FOUR – STRUCTURED SENSORY INTERVENTION**

This final level of intervention responds to those victims who are experiencing PTSD weeks following exposure, even months or years later. It also responds to those who may not fulfill the criteria for PTSD but are, in fact, experiencing one or more trauma-specific reaction and/or delayed grief reactions (traumatic grief). This level of intervention can actually be used with students who have been exposed to a singular incident or chronic multiple traumatizations.

*Structured Sensory Intervention for Traumatized Children, Adolescents, and Parents (SITCAP)* (Steele & Raider, 2001) is the result of eleven years of development, field-testing in school and agency settings, and research by The National Institute for Trauma and Loss in Children (TLC). SITCAP includes trauma-specific intervention programs for pre-school children three-to-six years - *What Color Is Your Hurt?*, children six-through-twelve years *I Feel Better Now!*, children six-through-twelve years and thirteen-through-eighteen years *Trauma Intervention for Children and Adolescents*, formerly known as – *Trauma Response Kit*; adults – *Adults and Parents in Trauma: Learning to Survive and Trauma Debriefing for Schools and Agencies.*

TLC has over 3,000 certified Trauma and Loss School Specialists, Consultants, and Consultant Supervisors using these intervention programs across the country in school and agency settings with children and families exposed to such incidents as murder, suicide, sexual/physical assault, domestic violence and other forms of violent acts; car fatalities, house fires, drownings, critical injuries, terminal illnesses, divorce, separation from parents and other non-violent critical incidents. These interventions are based upon well-researched cognitive-exposure based intervention strategies (Saigh & Bremmer, 1999; Malchiodi, 1998; Deblinger et. al, 1996; Roje, 1995; van der Kolk et. al, 1996; Pynoos, 1998).

The restoration of a sense of safety and power is a primary concern in each program. The activities are primarily sensory activities, as trauma is experienced at a sensory level, not a cognitive level. The structure of the intervention, however, directs those sensory experiences into a cognitive framework, which can then be reordered in a way that is manageable and empowering for children (Steele & Raider, 2001; Saigh, 1999). This intervention “is structured because with structure come a sense of control and safety” (Steele & Raider, 2001, p. 63). Trauma specific questions are used to help the victim give their experience a language, to tell their story. Sensory activities are used to help the victims make us a “witness” to what the experience was like. Once those tasks are completed, the child can now think differently about what happened.

**EXAMPLE**

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

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

The teen’s response was as follows:

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

At that moment in time, he experienced complete abandonment, betrayed by the adults in his world. Without appropriate intervention this could have easily triggered very self-defeating, even destructive responses. He had already begun to isolate himself, was missing school and was putting his future in jeopardy. If he had gone much longer without help, it would not have been unusual for him to start carrying a weapon, join a gang, or even actively seek out the kids who beat him with the intent of getting revenge. Being unable to trust the adult world was the worst part of his experience and one that often leads to destructive behavior and identification with the aggressor.

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

**COGNITIVE REFRAMING**

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

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

Cognitive approaches are largely used with exposure techniques. Frank (1988), Meichenbaum (1974), Saigh (1999), have all found the use of cognitive restructuring/reframing to be a valuable component for helping individuals move from “victim thinking” to “survivor thinking”. Cognitive reframing occurs everyday of a student’s life as a result of daily experiences with teachers and the education process. It is an essential component of trauma intervention and needs to be a part of the schools response.

PARENT INVOLVEMENT

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

An unstable parent creates an unstable child. A traumatized adult will find it difficult to help her traumatized child. Schwarz (1991) and many others have found that adults (parents), more frequently then children, experienced the greatest distress when presented with a trauma. van der Kolk, et. al (1996) wrote “most children are amazingly resilient as long as they have caregivers that are emotionally available.” When a child has been traumatized, parents also experience extreme distress and often are unable to adequately respond to their traumatized children without appropriate intervention.

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

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

SUMMARY

Research (Steele & Raider, 2001) documented that TLC’s intervention programs reduce severe levels of trauma reactions following violent as well as non-violent incidents. It demonstrated that the most severe victims saw the greatest reductions in reactions; contrary to the myth that little can be done to help those exposed to multiple traumas. It demonstrated that trained school counselors, social workers and psychologists can assist traumatized children in the reduction of symptoms across all diagnostic subcategories of PTSD, and for most, continue that reduction months after the last intervention.

Structured sensory interventions developed by TLC are unique for several reasons. They have been field-tested and researched in school settings and can be applied to students exposed
Research and Interventions to either violent or non-violent trauma inducing situations. Because grief is part of any trauma reaction, they are beneficial for managing grief as well as trauma. They are short-term, no more than eight sessions with each session following in a sequential manner addressing the major themes of trauma: fear, terror, hurt, worry, anger, revenge, guilt, accountability absence of safety, powerlessness, and victim thinking versus survivor thinking. Not all children will need all eight sessions, yet the design is such that each session is self-contained and outcome driven. Resource materials are provided for parents as well as students to assist in the education of victims and their families as to the nature of trauma and the normalization of its reactions.

Today, crisis intervention is a standard response in schools settings following critical incidents. Unfortunately, responses are not always orderly, nor appropriately used because of the lack of awareness and understanding of the nature of trauma, the way it can impact victims, the different levels of needs of victims, and the training needed to appropriately initiate the different levels of intervention from the least intrusive to the more intense strategies. Age appropriate resource materials (tools) are also needed to help facilitate successful intervention at the sensory level.

Understanding that trauma is not a cognitive experience, but a sensory one, dictates strategies that immediately restore, to victims, a sense of safety and renewed sense of empowerment/control in the face of fear and uncertainty generated by the incident. Reduction of the arousal level is critical to the restoration of pre-trauma cognitive processes, learning functions, behavior and performance. However, this must be approached systematically, as students or staff exposed to traumatic situations will have many varied reactions, some resolved with level one interventions, others needing up to level four intervention.

Children are most accessible in the school environment. We also learned as early as 1986 (Terr, 1990), following the Challenger space shuttle disaster, that children are vulnerable to trauma reactions even fourteen months later. Most educators understand that availability to the media today has left children overexposed to life events far too early in life and, as a result, children live in greater fear and anxiety than in past years. The school setting becomes an opportunity to help minimize that fear and restore a sense of safety. Valuable lessons can be learned if taught.

Students fully expect to hear from the adults in their environment following critical incidents. When educators fail to discuss the kind of critical incidents children are exposed to personally, via their school neighborhood or via the media coverage of major disasters, they are left to believe that “adults are afraid to talk”; “nobody knows what to do”; and/or “I better not bring this up – there is something wrong about it” (Terr, 1992 p.87). Critical incidents, disasters present and opportunity to teach children, to alter or expand their cognitive reactions, to stimulate their emotional growth, to be better prepared to negotiate the realities of today’s world.

Administrators generally appreciate the value of structured, orderly process when faced with difficult situations. It is far easier to exercise flexibility to unique elements of situations when structured boundaries exist. Crisis intervention in school settings need to also be structured and orderly, not only to minimize liability issues, but to maximize the opportunity to provide an immediate, efficient, outcome oriented resolution of that crisis. In essence, all members of school crisis teams need to be “on-the-same-page,” know exactly what their roles are, how and when they are to carry out these roles, and what is to be communicated to students, staff, families and communities. This is accomplished through a systematic initiation of protocols and levels of interventions of the kind discussed. The National Institute for Trauma and Loss in Children has been working with school districts across the country since 1990. Its protocols, intervention programs, strategies, and resource materials continue to be used and endorsed by schools and agencies across the country. ✷
REFERENCES


This little workbook is a great resource for youth ages 12 to 16. I have used the workbook with younger children, though it is recommended for the above group. *Pegasus’s Journey Through Grief* is an interactive workbook that validates grieving. Julie Stanick presents grief as a natural process for coping with death, a natural part of life. “When someone dies, we are filled with many feelings and emotions. It is important to work through these feelings so that we can remember our loved one but we also want to accept our new and different life. So we must go on a grief journey” (p.1).

*Pegasus’s Journey Through Grief* contains the message that we have choices. Mazes are presented with choices on how one continues on the journey through grief and life. I believe the underlying message here is that we have little control over many of life’s events. We do have control, however, of the reactions we take in these circumstances. Ms. Stanick engages the reader in making choices. There are positive messages throughout, yet the importance of grieving with all its pain is also offered.

The workbook addresses grief in a way in which youth can relate. The presentation of grief is very unassuming. A word search containing many grief emotions validates the uniqueness of the experience. Ms. Stanick challenges youth to find healthy releases for the natural emotion of anger. Memories are emphasized, as is self-care. It is a most engaging workbook and helps youth move through their grief.

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*Barbara McIntyre, Ph.D., ATR, LPC,* is an art therapist who has worked with children and families grieving the death of a loved one for twenty years. *She is the author of Jungle Journey; Grieving and Remembering Eleanor the Elephant, a children's book about grief. Dr. McIntyre also teaches art therapy and counseling skills for Wayne State University and Spring Arbor University.*
A thoughtful book for therapists willing to admit that non-talking child and adolescent clients can make us feel woefully inadequate and extremely frustrated, *No-Talk Therapy for Children and Adolescents* provides a fresh perspective. We’ve all had the kinds of clients that Straus describes. They fit many diagnostic pictures, and don’t talk for a variety of reasons, including “a lack of verbal and social skills, boredom, opposition for its own sake or for power, feeling trapped, disengagement, and shyness” (p. 108). These are the clients that test our patience and challenge our feelings of competence. Straus provides insight and strategies to engage such clients in a therapeutic encounter that do not rely upon words for success.

The book begins with several chapters offering general information about no-talk kids and why talk doesn’t work. Chapter 3, One Thing to Cheer About, explains the primary emphasis of no-talk therapy—providing someone to feel close to and something to feel proud of—and how to formulate goals with this simple purpose in mind. Chapter 4 discusses the importance of pulling together a team for the child, and drawing upon family, school, and community resources. In Chapters 5 and 6, the role of the therapist (Magician? Policeman?) and the importance of “Fun, Food, and Flexibility” are discussed. Chapters 7 and 8 look more closely at diagnosis, assessment, and therapeutic interventions. Chapter 9 concerns termination issues. Chapter 10 discusses how to survive and prevent therapist burnout. The book concludes with an Appendix of “Gimmicks, Gadgets, and Games” that are helpful to no-talk therapy.

Straus’s chapter on diagnosis and assessment delineates how difficult it can be to make an accurate diagnosis of someone who is not communicating productively. The multiple problems that these children may have can put them into several concurrent diagnostic categories. The diagnoses possible run the gamut: PTSD, reactive attachment disorder, ADHD, anxiety or depressive dis-

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**Gussie Klorer, Ph.D., A.T.R.-BC, L.C.S.W., L.C.P.C., is the director of the Graduate Art Therapy Counseling program at Southern Illinois University Edwardsville. She maintains a private practice in art therapy, specializing in work with children with abuse and neglect histories in foster care. Dr. Klorer is the author of Expressive Therapy with Troubled Children (2000, Jason Aronson Publishers) as well as numerous articles focused on clinical work. She is on the Editorial Board of Trauma and Loss: Research Interventions Journal.**
order, receptive and/or expressive language disorder, dysthymic disorder, adjustment disorder, oppositional defiant disorder, and conduct disorder, to name a few.

Straus illustrates her points through descriptions of her work with no-talk kids, beginning with Eliza, a “fierce and wary 15-year-old girl with long dusty dreadlocks, a pierced eyebrow, and an attitude” (p.1). Because no-talk kids fit many different descriptions, however, Straus emphasizes that it would be reductionistic to try to describe what makes interventions work. Rather, she discusses basic principles of successful interventions, and debunks some of the assumptions or myths prevalent in working with children and adolescents. These assumptions, which may work successfully for adult clients, include the ideas that talking about problems leads to solutions, getting in touch with bad feelings is beneficial, and that “the prospect of feeling better through talking is inherently motivating” (p.26). Her somewhat non-traditional approaches work. One of the most difficult things, she acknowledges, is sometimes trying to get parental support for things like playing board games, teaching magic tricks, and telling jokes, but these are some of the ways the therapist gets a foot in the door, and for no-talk kids, this begins the connection. Being silly, being real, making mistakes, are some of the ways the therapist engages with the child.

Her approach is firmly rooted in a systems theory, wherein she attempts to get information and involvement from as many people in the child’s life as possible in order to provide a comprehensive treatment plan. Part social worker, part counselor, part expressive therapist, part child advocate, part buddy, she sees her role as being the tie that pulls together a team (family/school/community) for the child and helps the child feel more lovable. A lot of this is time that the therapist does not get paid for, Straus warns, so the therapist who truly wants to do this kind of work must be ready for the level of commitment that it takes. The trials, tribulations, and stumbling blocks that Managed Care contributes to a child’s treatment plan are also discussed. Successfully navigating through Managed Care is one of the extra challenges for therapists today.

This is a wonderful addition to the reading list of therapists who are frustrated with certain clients and need a sense of direction and encouragement. It offers suggestions, success stories, a few failures, and lots of little pearls from someone who is a true natural working with children.
In this compelling and readable book, Ann Cattanach lets the reader know right up front her reasons for writing this text.

“This book is an attempt to make visible the abused child and suggest ways of helping such children feel worthwhile in a world where many children are still seen to be the possessions of their parents or other adults” (p. 9).

What impressed me so much about this work was her knowledge of children and their inherent strengths as well as their vulnerabilities. The first chapter introduces the reader to the basic rights and needs of all children, and then goes on in great detail to give definitions of abuse and trauma and the impact these have on the child’s emotional, physical and psychological well-being. The far reaching effects and the societal implications of ignoring these children are stressed and explained in easily understood language.

Chapter two deals with the modality of play as therapy and healing and why it is one of the processes of choice with children. Non-directive play therapy is a way for the child to build a relationship with a trusted adult, and to work through a process of healing that meshes with their view of the world and what their place in that complicated world can be, once the issue of abuse has been successfully dealt with. The author explains the rationale of play in therapy as well as the different types of play that all children universally engage in. By employing symbolic play, children are able to view their trauma from a safe distance by symbolically and metaphorically representing their pain.

The importance of place, the delineation of therapeutic boundaries and the choice of materials are extensively dealt with offering examples of play sessions that are illustrative of the benefits play therapy can have when used by a professional therapist. One of the things I found revealing were the insights offered and the use of the “blue mat” (p. 54), as the safe place for the play therapy to take place. The concept that we do not need a well equipped office and fancy materials was emphasized, along with the idea that a caring therapist needs few materials as long as she is imaginative and empathetic, and can provide a safe haven for the child to play out his/her feelings.

In chapter four the process of play therapy is explored in detail, explaining the three stages; relationship exploration and self esteem, and how they are used in the process to provide safety for the child to re-live the trauma and finally move on to a place where their identity is not tied into the traumatic events of the past. The ability to listen and be a witness to the child’s words and pain are of paramount importance.
Ann Cattanach’s extensive work with children is evidenced in this thoughtful and helpful book that reminds us that children love their parents, no matter what these parents may have done to them, and it is our job not to villainize them in the child’s eyes, but to work through feelings and emotions that allow them to grow into healthy and caring adults. She reminds us that the parents are a part of them and that to demonize the parent is to also demonize the child.

This practical and easy to apply book is recommended for anyone who works with abused children and would like further insight as well as practical and informative advice on healing the traumatized child. It would also be beneficial for anyone working in the area of bereavement, as many of these children must grieve the loss of parents and siblings when they are removed from abusive homes.

As the author so aptly states, “In this model of play therapy, the play is central to the attempt to heal the hurt child and is not just a stimulation to help the child to talk” (p. 48).

Since play has always been thought to be the language of children, we would all be well advised to allow and encourage play, and to be active participants whenever possible.