Trauma and Loss: Research and Interventions

The National Institute for Trauma and Loss in Children (TLC)  
A program of Children’s Home of Detroit (CHD)  
900 Cook Road  
Grosse Pointe Woods, Michigan 48236  
toll-free 877-306-5256 • 313-885-0390  
www.tlcinstitute.org

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NOTICE TO NON-PROFESSIONALS:
The information contained in this journal is not intended as a substitute for consultation with health care professionals.
Mission and Values

Mission

TLC’s mission is to provide direct services to traumatized children and families and to provide school professionals, crisis intervention teams, medical and mental health professionals, child care professionals and clinicians with trauma education, training, consultation, referral services and trauma-specific intervention programs and resource materials needed to help children, parents, families, and schools traumatized by violent or non-violent trauma-inducing incidents.

Vision

TLC’s vision is to make accessible to all traumatized children, parents, school personnel, and other professionals the most immediate and efficacious outcome-based trauma interventions appropriate to the level of severity, needs of victims, and the immediate, short-term and long-term needs of the community involved. Intervention consists of individual, group, and family participation; educational presentations; and debriefing and defusing trauma with victims, caretakers, teachers, and crisis team members. Outcome-based intervention will be provided for those exposed to potentially trauma-inducing incidents such as physical and sexual abuse, rape, assault, murder, school shootings, suicide, car fatalities, accidental and sudden deaths, fires, terminal illness, critical injuries, divorce, substance abuse, and foster care/residential placement. It is also TLC’s vision to design and develop intervention programs and trauma support materials to be used in those settings that provide immediate accessibility to children and families and to schools, medical, and mental health facilities.

Values

Research clearly documents that the effects of trauma decrease children’s ability to learn. School performance and behavior deteriorate. Traumatized children no longer feel safe and as a result withdraw, isolate themselves, or remain constantly worried about the future. Research clearly documents that when violence is involved, its victims, without appropriate intervention, identify with perpetrators and may become violent themselves.

TLC is dedicated to developing interventions that have been field-tested in school and agency settings and to researching their effectiveness. It is our goal to:

- restore a sense of safety;
- reduce the effects of trauma;
- help victims move from feeling powerless and hopeless to becoming survivors who are able to regain a sense of trust and reestablish future dreams and goals;
- minimize costs to the community by helping trauma victims return as vital, productive members.

To meet these goals and values, TLC has developed structured intervention tools and resource materials for use with children, parents, and others that provide consistent, orderly responses and positive intervention outcomes. Training is also provided to professionals, increasing timely accessibility to trauma-specific services for children and families through Certified Trauma and Loss School Specialists and Consultants.
Guidelines for Authors

Trauma and Loss: Research and Interventions

Trauma & Loss: Research & Interventions is the journal of The National Institute for Trauma & Loss in Children. The purpose of the journal is to provide practical information on research and interventions to help children, parents, families, and groups traumatized by violent and non-violent trauma-inducing incidents. The journal encourages submissions of manuscripts from clinicians, school personnel, crisis intervention and trauma specialists, medical and mental health professionals, and researchers.

Submissions are initially reviewed by the editor and then sent to members of the editorial board for review. Submissions are acknowledged upon receipt, and it generally takes 2 to 3 months between acknowledgement of receipt, and notification of the decision of the editorial board. Two copies of the journal are sent to the author upon publication, upon request.

Submissions which do not conform to the following guidelines will be returned without review.

1. Send four (4) copies to The National Institute for Trauma & Loss in Children, 900 Cook Road, Grosse Pointe Woods, MI 48236. Submission should be typed on 8 1/2 x 11 inch white paper. A computer CD with the manuscript saved in Microsoft Word, AppleWorks, or Text Only format should accompany the submission; in lieu of a CD, submissions may be sent electronically to [devaludwig@tlcinstitute.org or cmalchiodi@insightbb.com]. Please include your e-mail address.

2. Include an abstract of approximately 100 words summarizing the submission on a separate page.

3. Double-space the entire manuscript, including references, quotations, tables, and figures.

4. Leave margins of at least 1 inch on all sides.

5. Avoid footnotes.


7. Avoid the use of generic masculine pronouns and other sexist terminology. Use terms such as client, student, or participant, rather than research subject.

8. Tables and figures should be on separate pages. Figures (graphs, illustrations, line drawings) should be supplied camera-ready. Black & white photos or laser prints of art work are acceptable.

9. List author’s names, positions, titles, places of employment, and mailing addresses on a separate cover page so manuscript can be reviewed anonymously.

10. A brief biography should be submitted for each author, typed on a separate page.

11. Articles should not exceed 5000 words (about 20 typewritten pages). Brief reports and book reviews should not exceed 1000 (about 5 typewritten pages). Letters to the editor or commentaries should be under 300 words.

12. Trauma and Loss: Research and Interventions reserves the right to change copy to conform to the style established by the editor and editorial board.

For more information and examples go to the TLC web site at <www.tlcinstitution.org/journal.html>
As a father and a grandfather I cannot possibly imagine life without my children. I know in my heart, my life would never be the same. Back in 1989 when I was spending time with a group of parents of murdered children, a branch of the national organization of the same name (POMC), the one statement one of those mother’s made has always stayed with me. “When you lose a parent, you lose a part of your past, but when you lose a child you lose your future.”

There really are no words in our language to adequately describe how this tragic loss of life at Virginia Tech has impacted those suffering parents and families, nor how it will change their lives. That void, that horrid memory, will never go away. There will always be reminders. The hopes, the dreams they had for their children are gone. It will be a long struggle. We can only hope they are surrounded by those who can provide support, and that they have access to whatever resources they may need to some day find a new meaning, a new purpose in their lives. Words will mean very little to most of these parents, especially if they are not coming from other surviving parents. I would recommend Parents of Murdered Children http://www.pomc.com as a starting point when they are ready. As difficult as that mother’s painful statement was to hear back in 1989, it has been helpful many times over, primarily because it came from the heart of a surviving mother.

If you are working with a parent of a murdered child we encourage you to have that parent visit our web site for articles and links to other organizations whose primary focus is helping parents thorough this specific traumatic experience. Resources are also available to assist and help them respond to their surviving grieving, traumatized children.

TLC continues its efforts to bring such needed resources to you as helpers, as well as to the victims who come to you for help. The two research articles included in this issue describe what will result in a new, evidence-based, trauma focused intervention for at-risk, adjudicated youth in both outpatient and residential settings. It will also result in a significant updating of the “I Feel Better Now!” group program. Both will become available in late fall of this year. The research outcomes are more than statistically significant, however, what makes these programs so valuable is what the children who participated taught us about what was most helpful to them.

We do hope that we see you at our Second Annual Childhood Trauma Practitioners Assembly, July 17-20, 2007. Some of your colleagues will present the trauma practices they have found to be most helpful with
unique populations. We have always said, “There is no one intervention that fits every situation.” We always welcome new practices that have demonstrated outcomes. This year there will be 19 workshops in addition to Level-1 and Level-2 Certification trainings. The 240+ participants at last year’s Assembly walked away, not only with great information, but new practices. Do join us!

One of the recommendations participants made, as a group, at the 2006 Assembly was to develop a “message board” format so members could network and assist one another through unique or challenging situations. By this year’s Assembly we will initiate a forum program that allows members to seek out assistance from one another. This was one of several recommendations we have implemented as a result of initiating the assembly process. We look forward to giving you time during this year’s assembly to meet with your peers from across the country to discuss and identify best practices and recommendations related to what resources we can bring you in 2007-08. If you wish to review the summary of the 2007 Assembly discussion go to http://www.tlcinst.org/TLCAssemblySummary.html

Please read Deanne Ginns-Gruenberg’s book review of Dr. Bruce Perry’s new book, “The Boy Who Was Raised as a Dog: And Other Stories from a Child Psychiatrist's Notebook--What Traumatized Children Can Teach Us About Loss, Love, and Healing,” in this journal issue. Dr. Perry has a wonderful way of explaining the use of what he refers to as “neuro sequencing,” what we at TLC refer to as sensory-based interventions. Dr. Perry has, of course, spent many years studying the impact of trauma on the brain. His case studies really support the work TLC has been doing since 1990.

If you haven’t been to our web site for a while you might also want to take our newest “online” course, Reaching and Teaching Stressed and Anxious Students, prepared by Barbara Oehlberg, who will be presenting for us again at the summer Assembly.

On a final note, we have found that school counselors, social workers and psychologists are facing the ongoing shrinking of the amount of time they can actually spend intervening with students. It used to be they could run one-hour groups to help kids deal with difficult experiences like divorce. Now, they are fortunate if they can be allotted even thirty minutes. We all know what the long-term results will be to this limited access to personal help. Most agree this must change. In the meantime, TLC is developing a “One-Minute Interventions Handbook.” Of course, some interventions will take longer than one minute, but we must find effective ways to be there for kids, as witnesses to their experiences, as a safe person to be with in a time of crisis. We need to be the one person who can bring some “normalcy” into their otherwise chaotic, frightening, emotionally challenging young lives. We must work harder to be selective as to what we do in our brief contacts with children. We must also continue to help educational powers realize that intelligence without emotional well being puts children and others around them at-risk.

As always, we encourage you to keep us informed of new resources and new practices and we will do our best to do the same. ✤
Structured Sensory Therapy (SITCAP-ART) for At-Risk, Adjudicated Adolescents in Residential Treatment

Melvyn C. Raider, PhD, William Steele, PsyD, Margaret Delillo-Storey, LPC, Jacqueline Jacobs, MED, Caelan Kuban, MSW

Melvyn C. Raider is Associate Professor at Wayne State University School of Social Work and serves as Chair of the Post-Masters Certificate Program for Social Work with couples and families and is Chair of Research.

William Steele is the Founder and Director of The National Institute for Trauma and Loss in Children. He has developed, published and produced numerous books, articles, trauma-specific intervention programs and resource materials. He has trained well over 40,000 professionals.

Margaret Delillo-Storey is a therapist at the Multi-County Attention Center of Ohio and a staff member of Northeast Behavioral Health Center. She is a TLC Certified Trauma Consultant - Supervisor.

Jacqueline Jacobs is a Behavior Intervention Consultant and Certified TLC Trauma Specialist/Consultant Supervisor pursuing her PhD in Psychology from Northcentral University, Arizona.

Caelan Kuban is a Clinical Consultant at the National Institute for Trauma and Loss in Children. She provides short-term trauma intervention, conducts presentations, assists with community outreach for trauma-related incidents, and serves as the research coordinator for all evidence-based research projects at TLC.

Research funded by a grant from Annie E. Casey Foundation

Abstract

This randomized controlled study assessed the efficacy of a structured group therapy for traumatized, adjudicated adolescents in residential treatment. Youth were randomly assigned to a trauma intervention (SITCAP-ART) or to a waitlist/comparison group. The intervention included both sensory and cognitive/behavioral components. Standardized trauma and mental health measures were used. Study participants demonstrated statistically significant reductions in trauma symptoms, depression, rule breaking behaviors, aggressive behaviors and other mental health problems.

In recent years descriptive research evidence suggests that trauma and posttraumatic stress disorder (PTSD) is a significant psychological and emotional dysfunction manifest among populations in residential treatment organizations. Between 24 percent and 51 percent of male juvenile offenders exhibited symptoms of PTSD (Berton & Stabb, 1996, Burton, Foy, Bwanausi, Johnson & Moore, 1994). Similarly, 49 percent of female juvenile offenders demonstrated symptoms of PTSD (Cauffman, Feldman, Waterman, & Steiner, 1998). Foy et al indicate that the prevalence of post-traumatic stress disorder among adolescents is a function of the maltreatment, abuse, neglect and violence to which they are exposed (Foy, Madvig, Pynoos, & Camilleri, 1996). In 2001, the National Clearinghouse on Child Abuse and Neglect documented that almost one million children were identified by state child protective service agencies to be victims of child abuse and neglect. “More than half of child victims (57 percent) suffered neglect; 2 percent suffered medical neglect; 19 percent were physically abused; 10 percent were sexually abused; and 7 percent...
were psychologically maltreated” (National Clearinghouse on Child Abuse and Neglect Information, 2001, p.2).

For many of these maltreated children and adolescents, the trauma that maltreatment produces has a significant impact on their emotional, behavioral and cognitive functioning (Massachusetts Citizens for Children, 2001). As a result of the emotional, behavioral and cognitive deficits influenced by trauma, many children and adolescents develop dysfunctional coping mechanisms that may take the form of oppositional, defiant and aggressive behavior (Jacobs, 2005). Van Dalen (2001) suggests that many untreated traumatized children and adolescents demonstrate drug and alcoholic dependency as well as repeated delinquent behavior leading to adult criminal behavior.

Cognitive/behavioral therapies have been in widespread use to treat children and adolescents who have been traumatized. In fact, cognitive/behavioral therapy has been recommended as the “best practice” approach by the International Society for Traumatic Stress (Ovaert, Cashel, & Sewell, 2003) and American Academy of Child and Adolescent Psychiatry (AACAP, 1998). However, because of the cognitive distortions and deficits produced by traumatic events, it may be more difficult and potentially less effective to treat children and adolescents using only cognitive/behavioral therapy. It is the authors’ belief that the effectiveness of cognitive/behavioral therapy may be enhanced with the inclusion of sensory-based activities.

Therapeutic events and terror produce arousal that a neurophysiological response to trauma. Therefore, a traumatized child or adolescent’s predominant processing of the trauma will be in the mid and limbic areas of the brain, which deal with non-verbal information (Perry, 2006). Trauma is processed to a lesser extent in the neocortex area of the brain that involves reasoning, linear thinking, analysis, the ability to make sense of the experience.

The child or adolescent who remains or is frozen in a state of arousal due to past or current trauma has difficulty using cognitive processes. This happens when the stress hormones released during arousal impact the part of the brain responsible for these processes. For example, in an aroused state, it is difficult to process information, make sense out of one’s trauma experience, and identify and verbally express one’s emotions. Memory and the ability to attend, focus and retain information are also diminished. These cognitive deficiencies suggest the need for non-cognitive approaches to help children overcome or minimize the learning, emotional and behavioral problems deriving from the traumatic arousal.

Memory has two functions - implicit and explicit. Explicit memory sometimes referred to as declarative memory refers to primary cognitive processes. In explicit memory children and adolescents have access to language and can use words to describe what they are thinking and feeling. Explicit memory allows children and adolescents to process information, to reason, to make sense of their experience. These cognitive processes facilitate coping with traumatic arousal.

Sensory-based therapeutic activities are necessary to assist with the processing of the implicit memories of trauma and to restore more effective emotional functioning. When more effective emotional functioning is restored, cognitive/behavioral therapeutic activities can more effectively develop clearer thinking and positive coping strategies. The Structured Sensory Intervention for Traumatized Children, Adolescents and Parents – At-risk Adjudicated Treatment Program (SITCAP-ART), structured trauma treatment approach, which is the focus of this article, utilizes a series of drawing tasks and treatment specific questions that target the major sensations which are experienced in a traumatic event (e.g., terror, fear, worry, powerlessness). The premise of SITCAP-ART is that traumatic memories are experienced at a sensory level and must be reactivated in a safe environment in order to be moderated and tolerated with a sense of power and feeling of safety.

The purpose of this article is to report on a controlled research study to demonstrate the efficacy of
a structured group therapy for adjudicated youth in residential treatment - Structured Sensory Intervention for Traumatized Children, Adolescents and Parents – At-risk Adjudicated Treatment Program (SITCAP-ART). The facility that participated in the study was the Multi-County Juvenile Attention Center, Ohio in collaboration with Northeast Ohio Behavioral Health, North Canton and Cuyahoga Falls, Ohio.

TRAUMA INTERVENTION PROGRAM

SITCAP-ART is a modification of Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP), (Jacobs & Steele, 2003). The SITCAP-ART model is a comprehensive treatment approach designed to diminish the terror that exposed individuals experience and facilitate feelings of safety. When trauma reactions are normalized, the distinction between trauma and grief is emphasized. This structured protocol provides a session-by-session, situation-specific (e.g., school vs. agency) guide to intervention. It is appropriate for individuals who have experienced violent or non-violent trauma and is age-specific (preschoolers, 6 to 12 year olds, adolescents, and adults). Focusing on themes such as ‘hurt and ‘worry’ that accompany both violent and non-violent types of trauma enhances the generalizability of the model. The parent component encourages a supportive caretaker response and addresses past and present traumas in the parent’s life (Steele & Raider, 2001). SITCAP-ART is designed specifically for adjudicated youth integrates cognitive strategies with “sensory” and “implicit” strategies. SITCAP-ART is designed to achieve the successful cognitive re-ordering of traumatic experiences in ways that move adjudicated adolescents from victim to survivor thinking and in ways that allow them to become more resilient to future traumas. With increased cognitive functioning resulting from sensory based processing, the adolescent has a greater chance of benefiting from intervention that addresses the maladaptive coping behaviors characteristic of adolescents who have experienced long-term trauma reactions.

THE PROGRAM: SESSIONS

The program consists of 10-11 sessions, depending upon the progress made with each session. Seven of the sessions are group sessions and it is recommended that each group is comprised of no more than six participants. In the study all groups consisted of six adolescents. In addition, there is one individual debriefing session, one individual processing session and one parent/adolescent session. Each group session is scheduled for one hour and fifteen minutes.

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

THE INITIAL SESSION: EDUCATION

In this program, education is critical to recovery and it is also the first step in creating a sense of empowerment and safety for participants. Structuring statements, which provide the program facilitator with specific wording, are used at intake, and clearly identify how the process works, what will be expected, and what outcome can be anticipated. The time devoted to “structuring” the process helps to reduce anxiety. It also helps victims to make an informed consent. All too often interveners simply move directly into treatment without addressing the implications for the client. The client is not prepared to really confirm, “Yes, this is what I want.” SITCAP-ART uses specific resource materials for this educational component to ensure the adolescent has some sense of what he is about to experience as well as learn.

It is also of value to mention that, participants consistently report in final session surveys that the trauma educational component, that is included in all TLC trauma programs, has been extremely helpful and encouraging to them.

A key reason for this, observed by Ms. Jacqueline Jacobs, is that many of the adjudicated youth come to the SITCAP-ART program with a belief that they lack intelligence because of the historical difficulty they tend to have with their academic progress. Many of these juvenile offenders also have a belief, because of the long-term nature of their trauma reactions, that they have a mental illness which they have no chance of escaping. Without the understanding of the role that trauma has played in their learning and cognitive abilities, these adolescents are left to adopt these negative beliefs that can have a devastating impact on their self-esteem and sense of motivation.

Therefore, because of the importance of both the adolescent and parent understanding the connection between their trauma experience and learning and cognitive abilities, the SITCAP-ART program contains, in addition to the trauma education provided as part of the program, a simple and brief presentation which educates both the adolescent and the parents on the psychophysiology of trauma (i.e. brain and the survival response), and how it relates to the symptoms experienced as a result of the traumatic exposure. Once the participants understand the link between the trauma experience and the difficulty they are experiencing with concentration, memory and learning, as well as other symptoms such as insomnia, fear and anger, they tend to feel more hopeful about their abilities and more confident that they can overcome their trauma reactions and regain a sense of well being.

Participants also learn to recognize the link between their trauma experiences and delinquent behavior (aggression, defiance, substance abuse, and truancy). In addition, during this short, 10 to 11 week session program, most participants learn that they can begin to feel better with proper intervention. With many of the adjudicated participants, this knowledge and understanding play a role in improving an adolescent’s sense of hope and sense of self and the willingness of many participants to be more cooperative and open to additional therapeutic interventions which are often needed to assist with the relearning of more appropriate and healthy behavior patterns.

THE SECOND SESSION: DEBRIEFING

Each adolescent is scheduled for one-hour trauma debriefing session prior to beginning the group sessions. Debriefing is not recommended in a group setting so adolescents can identity those experiences they do not want others to know about yet they learn how these can be dealt with “anonymously” in a group setting. The debriefing session is a critical first step in helping to reduce the adolescent’s trauma reactions as well as anxiety about the group process. It is therefore, important that the adolescent has your undivided attention.
This is an abbreviated debriefing session, which provides the adolescent with an opportunity to confidentially revisit their trauma in the supportive, reassuring presence of an adult. It alleviates the need for the adolescent to reveal difficult details in the group sessions as well as helps to normalize the adolescent’s experiences. It also becomes an opportunity through the use of specific questions to redirect the adolescent’s understanding of the impact that this experience has had on their life and how this intervention process will help bring the adolescent relief from the trauma specific symptoms.

SESSIONS THREE – EIGHT: FOCUS ON THEMES, NOT BEHAVIOR

SITCAP-ART focuses on major experiences, sensations or themes of trauma throughout the process shifting the adolescent from victim thinking to survivor thinking. This process, therefore, does not direct itself to attempting to treat behavior, but rather the sensory experiences of trauma that fuel and drive the adolescent’s behavior. To accomplish this the intervener must remain in role of the witness versus clinician. To be a witness, the intervener must be involved in the adolescent’s telling of their experience by being curious about all that happened. To engage this “witness” role, the intervener must be very concrete and literal in response to all the elements of the experience, its details and the visual representations provide by the adolescent. If the intervener attempts to make sense of the adolescents’ emotional status by analyzing “why” they will not be able to experience the trauma as they are experiencing it. They will not “know it” as the adolescent knows it, and the adolescent will not experience the intervener as a witness, as someone who is with them in their experience. They will sense that they are alone and will withdraw to protect themselves. Part of becoming a witness is seeing how the victim now views themself and the world around them following the trauma. To see what the victim sees is to understand and know what will be helpful. Because trauma is a sensory experience the memory is often stored symbolically. Images – how they look at themselves and the world around them – defines what the trauma was like. A brief example might be the traditional therapeutic role of a therapist analyzing how a youngster is thinking or feeling instead of simply asking, “Of all the things that are going on in your life right now what is your biggest worry?” For some adolescents what the therapist might think may be a major concern related to the incidents the adolescent has been exposed to, may be completely different from what the adolescent is experiencing as a result of their exposure.

DRAWING

Drawing is a major component of SITCAP-ART. The experience of trauma is stored in implicit memory and is transcribed into iconic representations/visualizations. Iconic symbolization is the process of giving our experience a visual identity. Images are created to contain all the elements of that experience - what happened, our emotional reactions to it, the horror and terror of the experience. The trauma experience therefore is more easily communicated through imagery. “When a terrifying incident such as trauma is experienced and does not fit into a contextual memory, a new memory or dissociation is established” (van der Kolk, 1996, p. 287). When memory cannot be linked linguistically in a contextual framework, it remains at a symbolic level for which there are no words to describe it. To retrieve that memory so it can be encoded, given a language, and then integrated into consciousness, it must be retrieved and externalized in its symbolic perceptual (iconic) form (Steele, 2003).

In order to access this experience we must therefore use "sensory" interventions that allow adolescents the opportunity to actually make us witnesses to their experiences, to present us with their "iconic" representations, to give us the opportunity to see what they are now seeing as they look at themselves and the world around them following their exposure to a traumatic experience. In this sense “a picture is worth a thousand words”. Drawings provide a representation of those “iconic” symbols that implicitly
define what that experience was like for the adolescent, how that adolescent now views themselves and those around them. Drawing becomes a vehicle for communicating and externalizing what that experience was like.

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

DETAILS
Obtaining details is another very important component of the SITCAP-ART process as it helps to make sense of the experience. Trauma specific questions have been designed to help in the telling of the story and the provision of those details that allow intervener witnesses to better understand what the experience has been like for the adolescent. For the victim, details can provide a sense of control as well as sense of relief. For the intervener, details can point the way to helping the adolescent find relief. The structure of SITCAP-ART keeps the intervener and adolescent focused on details as a way of being able to later “see” the experience differently, to cognitively reframe it in a way that is manageable. Details also can provide information that helps to make sense out of what happened and may still be happening with the adolescent.

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

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

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

**COGNITIVE REFRAMING**

Cognitive reframing is scripted in SITCAP-ART to insure that the victim is provided a “survivors” way of making sense of their trauma experiences. The goal is to help move participants from “victim thinking” to “survivor thinking” which leads to empowerment, choice, and 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 in ways that are more manageable for them. Therapies that engage “explicit” cognitive processes are likely to be ineffective when traumatized adolescents are in the state of intense fear or terror. Steele (2003) Stein & Kendall (2004) and others now agree that adolescents must re-experience a sense of safety from and control (regulation) over those reactions induced by trauma before they can actually engage those explicit processes which are needed for cognitive restructuring— the reordering of the experience in a way they can now manage; in a way that this memory now becomes a resource versus a memory to be avoided.

For example, “Your experience has left you worried about what might happen next, this is certainly normal, but keep in mind, no storm comes to stay forever, your worry will in time also leave.”

**PARENT, FOSTER PARENT, GUARDIAN, PRIMARY CAREGIVER AND THERAPIST INVOLVEMENT**

Parents, foster parents, guardians, primary caregivers and therapists generally underestimate the impact trauma has on adolescents. Learning about trauma helps them to more adequately respond to the adolescent. Education is also helpful for primary caregivers who themselves have been traumatized. Education is an essential, necessary component to help them become aware of how their own unresolved traumas block their abilities to allow the adolescent to feel safe with them. Primary caregivers with their own history often discover that the adolescent’s experience threatens to bring all the terror of their own experience back to life. Unknowingly, they reject their adolescent’s cry for help or minimize the adolescent’s terror in hopes of avoiding their own fears and anxieties. It is important for the primary youth workers and clinicians in these settings to also have the same education and an understanding of trauma to avoid the same issues facing primary caregivers. This is a primary reason why the SITCAP-ART program is as structured for the trauma specialist or clinician as it is for the adolescent.

**METHOD**

The research was conducted at the Multi-County Attention Center in Ohio. The therapist was Margaret De Lillo-Storey, a staff member of Northeast Ohio Behavioral Health Center. Ms. Storey was trained in SITCAP-ART and certified by the Trauma and Loss Institute, which was the developer of the treatment model. To assure that each therapy session was conducted in compliance with the SITCAP-ART Model, Ms. Storey completed a Fidelity of Treatment Checklist (FTC). Analysis of the checklists indicated 98.5 percent Fidelity with the manualized treatment model. The Multi-County Attention Center clinical staff identified youth with documented multiple trauma exposure were recruited to participate in the research study. Two thirds of research participants were between 16 and 17 years of age. Eleven were male and nine were female. Most were white (85 percent). There was one Hispanic participant. The most frequently reported problems that contributed to placement in residential facility were behavior problems at home, criminal behavior, alcohol/substance abuse, behavior problems at school, and attachment problems. The most frequently documented trauma exposure were psychological maltreatment, physical maltreatment, sexual maltreatment, domestic violence, neglect, traumatic loss, and separation. Three quarters of
research participants experienced multiple trauma. Fifty-five percent of the research participants have been assessed to have PTSD and twenty percent traumatic or complicated grief. Youth and parents/guardians participated in an educational session in order to provide complete information about the SITCAP-ART trauma treatment program. Participation was voluntary requiring approval of both youth and parent/guardians. Both youth and their parents/guardians signed informed consent forms approved by Wayne State University Human Investigation Committee.

The group of research participants completed three instruments. The instruments were the Trauma Symptom Checklist for Children (TSCC-A) (Briere, 1996), the Youth Self Report (YSR) (Achenbach & Rescoria, 2001), and the Child and Adolescent Questionnaire (CAQ) developed by the authors (Steele & Raider 2001). In addition, the youth therapist, utilizing the Youth’s clinical case record completed clinical data form that gathered information on demographics, trauma exposure, and severity of symptoms, services utilization, and limited information about domestic environment.

Research participants were randomly assigned to two groups. The first group began immediate group treatment utilizing the SITCAP-ART program. The second group was the comparison/control group that remained on the waitlist for treatment and received the SITCAP-ART program identical to the treatment group when the treatment group had completed treatment (approximately ten weeks). Youth assigned to the comparison/control waitlist group were contacted bi-weekly by the group therapist, Ms. De Lillo-Storey in order to monitor any changes, escalations, and/or life event which required immediate intervention. Upon completion of the SITCAP-ART program, the treatment group completed the CAQ, TSCC and the YSR. The waitlist group completed these instruments as well at that time. After the waitlist group completed the SITCAP-ART program, they completed the CAQ, TSCC and YSR.

MEASURES

The Trauma Symptom Checklist for Children (TSCC-A) is a standardized self-report measure of post-traumatic and related symptoms for children 8 to 16 years of age. The instrument can be used with children as young as 7 and adolescent as old as 17 (Briere, 1996). The instrument was developed to assess symptoms of children who have experienced traumatic events, not to assess the DSM-IV-TR (American Psychiatric Association, 2000) construct of PTSD specifically (National Child Traumatic Stress Network, 2007). The version of the instrument utilized in this study evaluates children’s responses in five symptom domains: anxiety, depression, anger, post-traumatic stress, and dissociation. Dissociation has two subscales overt dissociation and fantasy. The five scales all demonstrate high internal consistency reliability (a = .82 – .87). A convergent validity study (Evans, et. al., 1994) correlating the TSCC and the Child Depression Inventory (CDI) demonstrated a moderate correlation of .68 with the TSCC depression scale. The TSCC was also correlated with the revised Children’s Manifest Anxiety Scale (RCMAS) correlations were moderate range from .51 - .63.

The Youth Self Report (YSR) is a standardized self-report measure that assesses problem behaviors in two summary domains: internalizing and externalizing (Achenbach, and Rescoria, 2001). These summary domains are comprised of eight symptom scales: anxious/depressed, withdrawal/depressed, somatic complaints, social problems, thought problems, attention problems, rule breaking behavior, and aggressive behavior. The YSR is designed to assess problem behaviors of children and adolescents 11 to 18 years of age. The YSR is a parallel instrument to the Child Behavior Checklist (CBCL). The YSR is one of the most widely used instruments in research that measures child and adolescent problem behaviors. Test/retest reliability is high (a = .87), internal consistency is very high (a = .95). Construct validity when used in conjunction with the CBCL is high (a = .85 - .89).

The Child and Adolescent Questionnaire (CAQ) (Steele & Raider, 2001) is a self-report measure of
post-traumatic stress symptoms as specified in the DSM-IV (APA, 1994). The CAQ was developed by Steele and Raider and is a modification of the Child PTSD Reaction Index (Frederick, Pynoos & Nader, 1992). The CAQ consists of 35 Likert-type questions comprising three scales. Scale I is the re-experiencing of the traumatic event, Scale II is avoidance of stimuli associated with the traumatic event, and Scale III is symptoms of increased arousal due to the traumatic event. In previous research (Steele & Raider, 2001), internal consistency reliability was assessed at intake, termination and three-month follow-up utilizing Cronbach’s alpha. Reliability of the re-experience traumatic event scale of the CAQ was high $\alpha = .82$ at intake, $\alpha = .86$ upon completion of intervention and $\alpha = .87$ at three month follow-up. Reliability of the avoidance scale of the CAQ was high at $\alpha = .78$ at intake, $\alpha = .80$ upon completion of the intervention, and $\alpha = .82$ at three month follow-up. Reliability of the arousal scale of the CAQ was moderate at $\alpha = .73$ at intake, $\alpha = .75$ upon completion of the intervention, and $\alpha = .76$ at three-month follow-up.

Raider and Steele utilizing data from the study under discussion as well as data from another controlled study assessing the efficacy of SITCAP-ART with adjudicated youth in a community setting in Georgia, correlated TSCC-A scores with CAQ.

Correlation of the CAQ total score with TSCC-A total score was good ($r = .671, p < 0.1$) and demonstrated statistical significance. Similarly the CAQ total score correlated with the TSCC individual scales produced correlations which were good and all statistically significant except for anxiety which had

<table>
<thead>
<tr>
<th>CORRELATION OF CHILD AND ADOLESCENT QUESTIONNAIRE (CAQ) AND TRAUMA SYMPTOM CHECKLIST FOR CHILDREN-A (TSCC-A) CLINICAL SCALES</th>
<th>N = 44</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TSCC</strong></td>
<td><strong>Anxiety</strong></td>
</tr>
<tr>
<td>Re-experiencing</td>
<td>Pearson $r$</td>
</tr>
<tr>
<td>Avoidance</td>
<td>Pearson $r$</td>
</tr>
<tr>
<td>Arousal</td>
<td>Pearson $r$</td>
</tr>
<tr>
<td>CAQ Total</td>
<td>Pearson $r$</td>
</tr>
</tbody>
</table>

** $p < 0.01$
a low correlation (r = .404, p < 0.01). CAQ scale scores were also correlated with the TSCC scale scores. Correlations were good and statistically significant (p < 0.01). However, the re-experiencing scale of the CAQ demonstrated a low correlation with the TSCC anger scale (r = .275, p = < 0.05). The strongest correlations were achieved in comparing the re-experiencing of traumatic events scale of the CAQ and the TSCC anxiety scale (r = .654, p = < 0.01), depression scale (r = .600, p = < 0.01), and the post-traumatic stress scale (r = .659, p < 0.01). Generally, it may be concluded that the Child and Adolescent Questionnaire (CAQ) demonstrated acceptable convergent validity with the Trauma Symptom Checklist for Children-A (TSCC-A).

RESULTS

TRAUMA SYMPTOM CHECKLIST FOR CHILDREN (TSCC-A)

Table I and Table II reflects paired t-tests for the seven scales of the TSCC. Table I reflects results of changes in scales from pre-test to post-test for the Control Group.

The Control Group did not demonstrate statistically significant changes (p = < .05).

Table II reflects results of changes in the seven scales. The TSCC from pre-test to post-test for the Treatment Group (1st Treatment Group and Waitlist Crossover). The Treatment Group demonstrated statistically significant reduction for symptoms in the anxiety, anger, dissociation, dissociation overt scales (p = <.05). A very impressive reduction in symptoms in the post-traumatic stress scale was achieved (p = < .01).

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean Pre-Test</th>
<th>Mean Post-Test</th>
<th>Mean Difference</th>
<th>t</th>
<th>Sig (12 tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>16.00</td>
<td>12.44</td>
<td>3.57</td>
<td>1.242</td>
<td>0.249</td>
</tr>
<tr>
<td>Depression</td>
<td>14.89</td>
<td>12.11</td>
<td>2.78</td>
<td>1.927</td>
<td>0.090</td>
</tr>
<tr>
<td>Anger</td>
<td>16.33</td>
<td>14.00</td>
<td>2.33</td>
<td>1.373</td>
<td>0.207</td>
</tr>
<tr>
<td>Post-Traumatic Stress</td>
<td>20.78</td>
<td>15.78</td>
<td>5.00</td>
<td>1.917</td>
<td>0.092</td>
</tr>
<tr>
<td>Dissociation</td>
<td>18.11</td>
<td>15.56</td>
<td>2.56</td>
<td>0.890</td>
<td>0.400</td>
</tr>
<tr>
<td>Dissociation Overt</td>
<td>12.22</td>
<td>11.22</td>
<td>1.00</td>
<td>0.524</td>
<td>0.614</td>
</tr>
<tr>
<td>Dissociation Fantasy</td>
<td>5.89</td>
<td>4.33</td>
<td>1.56</td>
<td>1.346</td>
<td>0.215</td>
</tr>
</tbody>
</table>
Table III and Table IV reflect paired t-tests for the three trauma scales in the CAQ. Table III reflects results of pre-test and post-test comparisons for the Control Group. Changes from pre-test to post-test for all scales did not achieve statistical significance (p = < .05).

Table IV reflects results of the pre-test to post-test comparisons for the Treatment Group. The Treatment Group demonstrated very substantial reductions in trauma symptoms for all three scales. The re-experiencing and avoidance scales demonstrated highly statistically significant reductions in symptoms (p = <.01).

**CHILD AND ADOLESCENT QUESTIONNAIRE (CAQ)**

Table III and Table IV reflect paired t-tests for the three trauma scales in the CAQ. Table III reflects results of pre-test and post-test comparisons for the Control Group. Changes from pre-test to post-test for all scales did not achieve statistical significance (p = < .05).

Table IV reflects results of the pre-test to post-test comparisons for the Treatment Group. The Treatment Group demonstrated very substantial reductions in trauma symptoms for all three scales. The re-experiencing and avoidance scales demonstrated highly statistically significant reductions in symptoms (p = <.01).

**YOUTH SELF REPORT (YSR)**

Table V and Table VI reflects paired t-tests for changes in syndrome scales on the YSR. Table V reflects results of the pre-test to post-test comparisons for the Control Group. The Control Group did not demonstrate any statistically significant changes in symptoms in syndrome scales.

Table VI reflects results of pre-test and post-test comparisons for the Treatment Group, which includes the original Treatment Group as well as the waitlist group. (N = 19). As specified in the crossover protocol, the waitlist group received treatment after the original Treatment Group completed the SITCAP-ART interventions.
The anxious/depressed, withdrawn/depressed, thought problems, behavior, internalizing behavior, externalizing behavior and total problems scales reflected reductions in symptoms and achieved statistical significance (p = .05). The rule breaking and aggressive behavior scales demonstrated impressive reductions in symptoms and achieved statistical significance at the p = <.01 level.

The somatic complaints and social problems scales reflected a reduction in symptoms but did not achieve statistical significance. The very impressive reductions in the rule breaking and aggressive behavior scales are of particular importance for residential treatment settings.

| TABLE III – CHILD AND ADOLESCENT QUESTIONNAIRE (CAQ) |
| Paired t-test N = 9 CONTROL GROUP |
| Scale | Mean Pre-Test | Mean Post-Test | Mean Difference | Sig (2 tailed) |
| Re-experiencing Traumatic Event | 38.11 | 34.89 | 3.22 | 0.619 | 0.553 |
| Avoidance of Stimuli of Traumatic Event | 39.22 | 39.22 | 0.00 | 0.000 | 1.000 |
| Symptoms of Arousal Due to Traumatic Event | 33.67 | 30.56 | 3.11 | 0.695 | 0.506 |

| TABLE IV – CHILD AND ADOLESCENT QUESTIONNAIRE (CAQ) |
| Paired t-test N = 20 TREATMENT GROUP (1ST TREATMENT GROUP AND CROSSOVER WAITLIST) |
| Scale | Mean Pre-Test | Mean Post-Test | Mean Difference | Sig (2 tailed) |
| Re-experiencing Traumatic Event | 31.75 | 21.25 | 10.50 | 5.214 | 0.000** |
| Avoidance of Stimuli of Traumatic Event | 36.90 | 22.05 | 14.85 | 5.732 | 0.000** |
| Symptoms of Arousal Due to Traumatic Event | 28.95 | 20.5 | 8.45 | 4.413 | 0.000** |

** p = < .01
DR O P OUTS

There were five study participants who dropped out of the research study in the early sessions of
the group therapy. Dropouts were similar in demographics to those who completed the program. Pre-test
scores on the CAQ and the TSCC were lower on average than the pre-test scores of those who completed
the program. It may be hypothesized that dropouts may have been experiencing fewer trauma symptoms
than those who completed the SITCAP-ART program.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean Pre-Test</th>
<th>Mean Post-Test</th>
<th>Mean Difference</th>
<th>t</th>
<th>Sig (2 tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious/Depressed</td>
<td>11.111</td>
<td>12.333</td>
<td>-1.222</td>
<td>1.178</td>
<td>0.273</td>
</tr>
<tr>
<td>Withdrewn/Depressed</td>
<td>8.778</td>
<td>6.889</td>
<td>1.889</td>
<td>2.089</td>
<td>0.070</td>
</tr>
<tr>
<td>Somatic Complaints</td>
<td>10.333</td>
<td>8.889</td>
<td>1.444</td>
<td>0.945</td>
<td>0.372</td>
</tr>
<tr>
<td>Social Problems</td>
<td>7.556</td>
<td>9.000</td>
<td>-1.444</td>
<td>1.050</td>
<td>0.324</td>
</tr>
<tr>
<td>Thought Problems</td>
<td>10.111</td>
<td>10.000</td>
<td>0.111</td>
<td>0.144</td>
<td>0.889</td>
</tr>
<tr>
<td>Attention Problems</td>
<td>12.111</td>
<td>10.222</td>
<td>1.889</td>
<td>2.163</td>
<td>0.062</td>
</tr>
<tr>
<td>Rule Breaking Behavior</td>
<td>16.556</td>
<td>15.333</td>
<td>1.222</td>
<td>0.627</td>
<td>0.548</td>
</tr>
<tr>
<td>Aggressive Behavior</td>
<td>17.333</td>
<td>15.889</td>
<td>1.444</td>
<td>1.127</td>
<td>0.292</td>
</tr>
<tr>
<td>Internalizing Behavior</td>
<td>27.111</td>
<td>28.111</td>
<td>-1.000</td>
<td>0.597</td>
<td>0.567</td>
</tr>
<tr>
<td>Externalizing Behavior</td>
<td>34.889</td>
<td>31.222</td>
<td>3.667</td>
<td>1.043</td>
<td>0.327</td>
</tr>
<tr>
<td>Total Problems</td>
<td>97.000</td>
<td>96.667</td>
<td>0.333</td>
<td>0.055</td>
<td>0.958</td>
</tr>
</tbody>
</table>
The first hypothesis that the treatment group would demonstrate statistically significant reductions in trauma symptoms at the conclusion of treatment was supported. (The comparison/control group did not demonstrate statistically significant reductions in trauma at that time.) The TSCC-A demonstrated statistically significant reductions in anxiety, anger, post-traumatic stress, and dissociation. The CAQ demonstrated statistically significant reductions in the re-experiencing, avoidance and arousal scales. These results are consistent with the findings of Ovaert et al (2003) who assert was the first controlled study to evaluate the efficacy of a structured cognitive behavioral therapy program for traumatized incarcerated youth. The researchers used a measure of post-traumatic stress PTSD-RI (Frederick, 1982) that is somewhat similar to the CAQ. They did not use the Trauma Symptom Checklist for Children.

The second hypothesis that the treatment group would demonstrate statistically significant reductions in mental health symptoms was supported (The Waitlist/Control Group did not demonstrate statisti-
cally significant reductions in mental health symptoms at that time). The Youth Self Report (YSR) demonstrated statistically significant reductions in total problems: depression, anxiety as well as withdrawn, thought problems, attention problems, rule breaking behavior, aggressive behavior, internalizing behavior, externalizing behavior. Very significant reductions were demonstrated for rule breaking behavior, aggressive behavior and externalizing behavior. Aggressive behavior and rule breaking behaviors are highly associated with at-risk adjudicated youth and are behavioral manifestations of the arousal response to trauma victimization (Ford et al, 2006). The reduction of arousal symptoms reported by the TSCC and CAQ are also supported by the YSR’s reported reduction of these behavioral manifestations of arousal.

The study discussed earlier (Ovaert et al., 2003) did not demonstrate reductions in symptoms of anxiety, anger and depression. Goenjian (1997), in a study of the outcome of psychotherapy among early adolescents after trauma, similarly did not report reductions in depression after trauma treatment.

The very impressive reduction in mental health problems, especially reductions in rule breaking and aggressive behaviors of SITCAP-ART participants, suggests the hypothesis that sensory based therapeutic activities in combination with cognitive/behavioral therapy is more likely to reduce mental health symptoms among traumatized youth than cognitive/behavioral therapy alone. SITCAP-ART uses sensory-based activities, which are then followed by cognitive reframing and processing. From a neurological standpoint ART initiates intervention that address the implicit (sensory) memories of trauma and only thereafter address the explicit (cognitive) responses to traumatic exposure. For most youth trauma is initially an implicit experience (Steele & Raider, 2001; Steele, 2003; Van Dalen, 2001; Rothschild, 2000; Saigh, 1999; Perry, 1999; Michaeasu and Baettig, 1996; van der Kolk, 1987), SITCAP-ART leads to emotional regulation and clearer thinking which allow the youth to better understand how their traumatic experiences have activated their thoughts and emotions to avoid further victimization by engaging in those behaviors associated with delinquency.

Following implicit processing SITCAP-ART may influence the reintegration of implicit memories with the cognitive reframing of the implicit trauma memories, a “rewriting” or “reordering” of the experiences in ways the child/adolescent can now best manage. It may be hypothesized that the significant gains reported by the TSCC, YSR, and CAQ are the result of the sensory/cognitive integration process of the SITCAP-ART program.

Since completion of the SITCAP-ART group therapy program, therapists and staff members have anecdotally observed positive attitude and behavioral changes in the youth. They are not as negative, less aggressive, and less resistant. There have been no “repeat lock ups” reported for youth who participated in the program. The Superintendent felt so positively with regard to the outcomes of the SITCAP-ART program as to suggest providing the program for all youth in residential placement. Prior to the use of SITCAP-ART in this controlled research study the therapy was field tested in 2005. Eighty-five at-risk adjudicated adolescents in Gainesville and Jasper, Georgia participated in the field test under the supervision of the Juvenile Court. Following SITCAP-ART group therapy field test, in a descriptive satisfaction survey, 100 percent of the 85 participants reported a reduction in trauma symptoms as indicated by a comparison of pre-trauma and post-trauma PTSD scores on a scale of 1 to 10, 90 percent indicated they definitely felt better following intervention using “9” and “10” to rate that difference. One year following this field test, 85 percent of the youth had no additional “criminal” contact with the court.

The results of this study, although impressive, must be viewed as preliminary. The control group was small and the treatment group was of modest size. Further research in additional residential settings is necessary. It is clear that SITCAP-ART has demonstrated value for assisting traumatized adjudicated youth in residential settings with both trauma symptoms and mental health symptoms. “Williams (2002) and Sccker, et al., (2004) reported that delinquent youths who experienced dysregulated emotions and sur-
vival or victim based information processing will be able to become responsible citizens if they are assisted in gaining the capacity to manage their emotions and think clearly (Ford, et al., 2006, p. 18).” The SIT-CAP-ART program demonstrated significant gains in these two critical areas.

References


Outcomes After Groups for Children Exposed to Violence with Behavior Problems

Vincent J. Palusci, MD, MS, Rosalynn Bliss, MSW, LMSW, Pat Crum, BA

Vincent J. Palusci, MD MS is the Helpie Endowed Professor of Pediatrics at Wayne State University School of Medicine and Medical Director of the Child Protection Center at the Children’s Hospital of Michigan. Dr. Palusci is a child abuse pediatrician with extensive clinical experience in providing medical care for maltreated children. He received his medical degree from the University of Medicine and Dentistry of New Jersey and a Master of Science in epidemiology from the Michigan State University College of Human Medicine. He has edited several books and articles and his current research interests include outcomes after physical and sexual abuse and child maltreatment prevention.

Rosalynn Bliss, MSW LMSW is currently Director of Clinical Services at St. John’s Home in Grand Rapids, MI. She is a Medical Social Worker who works with children that have been maltreated, facilitated parenting education programs, and provides interventions for children that have experienced a traumatic event. She earned a Bachelor’s of Arts Degree in Psychology and Criminal Justice from the University of South Alabama and a Master of Social Work Degree from Michigan State University. Ms. Bliss holds certifications in Responding to Trauma and Loss in Children and Critical Incident Stress Management.

Pat Crum, BA is a Parent Counselor with the Child Protection Team at DeVos Children’s Hospital. She has 25 years experience as a professional trainer, parent educator, presenter and group facilitator. Pat is also a Nationally Recognized Trainer/Consultant for the Nurturing Parenting Programs and Co-Founder of the Family Nurturing Center of Michigan. Pat holds certifications in Brain-Based Learning, Responding to Trauma and Loss in Children, and Gender-Based Learning.

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We wish to thank Dr. Steven Pastynak for his help with interpreting testing, Dr. Steven Ondersma for his review of the manuscript, and the DeVos Children’s Hospital Foundation for their financial support for the children’s groups. This paper was presented in part at the 15th National Conference on Child Abuse and Neglect in Boston, April 20, 2005.

Abstract

Exposure to violence in childhood is associated with a range of negative physical, behavioral, and emotional consequences. Therapeutic groups offer the potential to address short-term trauma symptoms and prevent post-traumatic stress (PTS) in children at risk due to violence exposure. We evaluated a manualized group therapy approach developed by the National Institute for Trauma and Loss, Inc and conducted 8-week therapy groups for 53 children 7-12 years of age in eight separate groups. We noted clinical improvements in child behavior and trauma-related symptoms in most children, while boys, younger children and those exposed to domestic violence had greater clinical improvement in some scales. Gains were not affected by child depression, family or medical history. We conclude that groups can be considered for children ages 7-12 years with behavior problems and violence exposure, but a more definitive recommendation for their use awaits further research.

KEYWORDS: Violence exposure, post-traumatic stress, behavior problems, groups

NOTE FROM WILLIAM STEELE, TLC DIRECTOR:

The following article describes the outcome of an independent research group who used the TLC program, I Feel Better Now! with children living with, and exposed to, domestic violence. The outcome
definitely demonstrates the value of the I Feel Better Now! Program.

Currently, TLC is completing it’s own evidenced-based research of I Feel Better Now! with 100 at-risk, traumatized children in grades 2-5. These children were screened for the presence of trauma and then randomly placed in treatment groups and/or wait list (control) groups.

Preliminary data shows significant symptom reduction across all DSM-IVR subcategories. Combined, these two studies provide significant research to support the value of I Feel Better Now! with children exposed to multiple traumas. These studies also demonstrate the program’s usability in both school and agency settings.

INTRODUCTION

Children are increasingly exposed to violence, both at home and in the community (Hurt, Malmud, Brodski & Giannetta, 2001), and it is accepted that direct victimization by physical or sexual abuse or indirect exposure to robberies, beating, stabbing, shooting and other community violence can have negative effects on children’s medical, emotional, behavioral, and school functioning (Christian, Scribano, Siedl & Pinto-Martin, 1997; Fergusson & Horwood, 1998; Teicher, 2002). Additionally, it is estimated that sixty percent of children who witness violence in the home also experience direct physical or sexual abuse (Knapp, 1998).

Trauma-specific behavioral symptoms noted in school-age children after exposure to violence include eating disturbances, sleep problems, developmental regression, language lag, fighting, and school truancy, with increased physical complaints, decreased attention, and secondary enuresis (Delaney-Black, Covington, Ondersma, Nordstrom-Klee, Templin, Ager, Janisse & Sokol, 2002). Children reporting high levels of exposure to interparental violence are more likely to have borderline to clinical level behavior problems (Kernic, Wolf, Holt et al, 2003; McFarlane et al, 2003) or to have elevated rates of adjustment problems at age eighteen, including mental health problems, substance abuse, and criminal offending (Delaney-Black et al, 2002). Young children witnessing community violence (CV) have high ratings of overall distress and other adverse social, emotional, and academic outcomes, including behavior problems, depression, and affect dysregulation and other symptoms of post traumatic stress (PTS) even when there is no violence at home (Fergusson et al, 1998; Teicher, 2002; Delaney-Black, et al, 2002; Knapp, 1998; Kilpatrick & Williams, 1998; Briere, 2006). Being abused, exposed to domestic violence (DV), and having a mother using substances was also associated with a higher number of physical health problems such as asthma, allergy, gastrointestinal problems and headache (Graham-Bermann & Seng, 2005). There are also biologic correlates with changes in the hypothalamic pituitary axis and other areas on positron emission scanning (Augustyn et al, 1995; Yahuda, 2002; Zuckerman, Augustyn, Groves & Parker, 1995).

Treatment for child and adolescent post-traumatic stress (PTS) appears to lead to greater improvement than either no treatment or routine community care, but further research is needed to develop evidence-based child trauma treatment (Taylor & Chemtob, 2004). As a step towards this goal, the National Child Traumatic Stress Network, funded the U.S. federal Substance Abuse and Mental Health Administration, identified eight essential elements of trauma-informed practice that can assist in making appropriate referrals to services (http://mentalhealth.samhsa.gov/cmhs/). One of these elements suggests that children who have been exposed to significant levels of violence can benefit from educational groups which have the potential to mitigate the short and long-term impacts of trauma in children (Taylor, Wilson & Igelman, 2006). We undertook this pilot study to examine: (a) changes, if any, in child behavior and trauma-specific symptoms were noted after treatment groups; (b) the feasibility of conducting groups for children with violence-specific symptoms in a medical setting, and (3) whether changes, if any, were moder-
ated by child age, gender, medical history, parent history, child depression, and/or the amount and nature of violence exposure.

**METHODS**

**Participants**

The protocol and procedures were reviewed and approved by our institutional research and human subjects protection committee. We then identified children with potential violence-related symptoms who were referred to us because of behavior problems. These children came from a variety of sources, including healthcare professionals, domestic violence service providers, mental health providers, and families themselves. Upon referral, project staff met with parents to informally potential exposures to violence and whether the child was exhibiting trauma-related behaviors such as hypervigilance, cognitive dysfunction in attention, sleep difficulty, irritability, traumatic dreams, feelings of powerlessness and hopelessness, intrusive thought, detachment, diminished interest in activities, and phobias.

Families were offered participation in a trauma group if the children were: (a) age 7-12 years; (b) lived within 50 miles of our center; (c) exhibited trauma-related behaviors, and (d) had legally-responsible parents or caretakers who were willing to participate in screening and group procedures after providing informed consent. Children were excluded if: (a) their parents believed they could not safely participate in a group setting with other children (history of severe disruptive behavior, uncontrolled severe physical or mental disorders), or (b) the child was unable to communicate at a developmental level consistent with the proposed group. Children and families not enrolled were offered standard hospital and community service referrals as appropriate.

**Intervention/Program**

We used a previously developed structured intervention for children exposed to incidents such as murder, suicide, sexual physical assault, domestic and other violence (Steele & Raider, 2001). This manual, called the "I Feel Better Now" program, provides a structured format with activities that target common trauma reactions and group processes based upon an educational model of teaching, exploring, guiding, normalizing, and reframing experiences (Kordas, 1998; Steele, 1999; Steele & Raider, 2001). All sessions were provided by two medical social workers and parent counselors who were certified in this approach by the National Institute for Trauma and Loss. We offered a total of 8 groups over an eight-week period, with one 2-hour session per week, following a set outline of topics (Table 1). Groups included 8-10 children each and were held in child-friendly rooms within community agencies or hospital settings designed to provide privacy for parents and children. Program guidelines included many opportunities for choice by participants. Participants were given permission to not do or say anything that made them uncomfortable, including participating in discussions, activities, filling out forms and assessment tools, and continuing participation in the study. We added enhancements and experiential activities such as music and movement to relieve anxiety, with additional exercises (‘brain gym’, breathing and relaxation exercises, cooperative games focusing on problem-solving, trust, and self-soothing techniques).

**Instruments**

During the initial assessment, study forms and tools were administered to parents and children (pre-tests). Parents completed the consent form and a behavior inventory (CBCL), and children completed measures of violence exposure (Vex-R), depression (CDI), and trauma symptoms (revised Trauma Symptom Checklist for Children, TSCC-A) with assistance from study staff. Families were then provided with a complimentary copy of *What Parents Need to Know: Help for Parents of Grieving and Traumatized*
Children (Steele, 1999), information about group times and location, and how to contact study staff should they have questions or concerns. Upon completion of the group, study forms and tools were administered to parents and children (post-tests), with parents completing a second CBCL and children completing a second TSCC-A.

The revised "Violence Exposure Scale for Children" or VEX-R (Fox & Leavitt, 1995) measures community/school assaults, family perpetrators of abuse in the home setting, witnessing or indirect exposure to violence, and threats with weapons. It is a 22-item questionnaire that is appropriate for children ages 3 to 12 and provides information regarding lifetime exposure to violence, type, frequency and severity regarding the incidents, and requires 10-15 minutes is required for administration (Hamby & Finkelhor, 2001). Cartoon pictures are shown depicting several violent acts and children are asked to identify the frequency of their personal exposure. Point values are assigned for each violence type frequency and are summed to a total Vex score. Study staff noted the type of violence exposures reported by the child as one or more of child physical abuse, child sexual abuse, community violence or domestic violence. The types of violence exposures were confirmed with the parent.

The Child Depression Inventory (CDI) (Kovacs, 1992) is a 27-item self-report inventory that assesses depression in children ages 3-17 years of age. This inventory assesses a wide range of depressive symptoms such as anhedonia, negative mood, interpersonal problems, ineffectiveness, and negative self-esteem. The CDI is typically administered to the child as a paper and pencil self-report inventory. Children are asked to read the sentences and pick the sentence that best describes them over the last two weeks.

The Achenbach Child Behavior Checklist (CBCL) (Achenbach, 1991) is a 113-item measure of a child’s behavioral functioning. A report profile is created that displays clinically significant elevations for the individual based on other children in that age group. Scales reported are withdrawal, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behavior, aggressive behavior, and sex problems. Composite internalizing and externalizing scales and total scores are reported.

The Trauma Symptom Checklist for Children (TSCC-A, Briere, 1996) is a 44-item self report inventory that assesses trauma symptoms. The TSCC-A differs from the standard TSCC in that sexual victimization items have been removed. It is used to identify acute and chronic post-traumatic symptoms in children, and it assesses anxiety, depression, anger, posttraumatic stress and dissociation, with separate scores reported for overt dissociation and fantasy.

**Data Analysis**

Frequencies for child, family and other characteristics were broken down into low violence (Vex-R < 31) and high violence exposure groups (Vex-R ≥ 30) based on preliminary data on the average Vex-R score to be anticipated. Means and standard deviations were calculated for CBCL total scores and internalizing and externalizing subscales. TSCC-A subscale scores were used for analysis. The primary study question was evaluated using paired t-tests for comparison of pre- and post-test scores. Additional Chi-square analyses evaluated pre-post differences in clinical levels of symptoms (T score ≥ 60) on the TSCC-A. Comparison to age, gender, and violence exposure type were made both within and among groups using Student t-tests and regression models. Clinical improvement was defined as moving from an elevated TSCC-A score ( ≥ 60) to the normal range (T score < 60) on post-tests. The SAS statistical package version 9.1.3 (SAS Institute, Cary, NC) was used, and alpha was set to 0.05 for all analyses.
RESULTS

Over a two-year period, nine groups were held for a total of 63 children, ages 7-12 years. Of these, 53 were able to attend the majority of group sessions and complete all pre- and post-tests. In addition, comments and drawings were provided by a number of children and their parents. No children or families withdrew because of negative emotional responses, but 10 children did not complete the group because of difficulty attending or inability to complete follow-up measures. Overall, just over half of the children were female, and children averaged just under 9 years of age (Table 2). Notably, almost three-fourths of parents reported that they were abused during their childhood, and one-third reported prior substance abuse. Over one-third of the children were being treated for attention deficit disorder, one in six had been treated for other mental health disorders, and one in ten had asthma.

Level of violence exposure varied widely. Groups were composed from children with varying violence exposures, including domestic violence, child maltreatment (child sexual and/or physical abuse), or community violence. More than 80% of children reported some exposure to domestic violence (Table 2). One-third of children were reported to be victims of child physical abuse by their parents, with one-fifth witnessing community violence, and a small number (3%) were reportedly sexually abused. On average, children reported witnessing a minimum of 10-15 violent acts which resulted in mean Vex-R scores of 29; many (41%) had higher violence scores, which suggested multiple, frequent violence exposures. Among those in the high violence groups, a larger number had been exposed to domestic violence (P<0.05). At the start of the groups, children in the high violence group were more anxious, depressed, and angry and had more post-traumatic stress. Only anger was statistically higher (P<0.05). No other statistically significant differences were noted in age, gender, medical or maternal history or violence exposure between the groups.

CBCL and TSCC-A scores declined significantly following group participation (Table 3). Statistically significant differences were noted between the low and high violence groups in the post-test total CBCL score, the pretest TSCC-A depression subscale and the post-test TSCC-A depression and post traumatic stress scales. Over the entire range of violence exposure, there were no statistically significant pre-test/post-test differences in any of the scales.

When defined as changing from elevated (T≥60) to normal (T<60) scores, the majority of children improved in all areas after groups (Table 4). There was no difference based on level of violence exposure. In logistic regression models (Table 5) for clinical improvements in trauma symptoms, various factors contributed to clinical improvements in TSCC scores, with boys being more likely to have improvement in anxiety (odds ratio=11.4), depression (7.42) and post-traumatic stress symptoms (5.04). Higher violence exposure was associated with less improvement in anxiety (0.91) and post-traumatic stress (0.89). Domestic violence was associated with improvements in anxiety (23.9) to anxiety and post-traumatic stress scores (11.0). Older children were less likely to have improvement in dissociation overall (0.51/yr) and fantasy (0.44/yr).

DISCUSSION

We observed clear and clinically significant reductions in behavioral problems and trauma-related symptoms following group therapy. These reductions were present regardless of baseline level of exposure to violence. Further, most children successfully completed the 8 group sessions. Despite the fact that the children were referred for assessment only because of behavior problems (and were not concurrently receiving other formal mental health treatment), our participants had high levels of clinical scores on the TSCC-A, with 35-70% having T scores above 60. This is similar to scores others have reported for children exposed to violence. McFarlane noted elevated CBCL internal, external and total scores in children
ages 6-11 years, with lower scores in families where there was no reported DV (McFarlane et al, 2003). Kernic noted this as well, with even worse internalizing, externalizing and total CBCL scores when children were directly victimized in addition to witnessing DV (Kernic, Wolf, Holt, McKnight, Huebner, & Rivara, 2003).

We were surprised to find that over 80% reported witnessing violence at home. The high proportion of parents who reported abuse as children or substance abuse was concerning as were the number of children reporting past direct physical or sexual victimization. The proportion of children with ADHD or other prior medical and mental health treatment was not very different from that seen elsewhere in our state, where health symptoms have been linked to violence exposure and traumatic stress symptoms (Graham-Bermann & Seng, 2005). When we reviewed the children’s violence reports with their parents, we were impressed by how parents consistently underreported the number, type and frequency of violence exposure compared to their children’s reports, as noted by others (Augustyn et al, 1995). More violence exposures were seen in older children which is not surprising given they have more time to be exposed. The type of violence exposure does affect the changes in some symptoms after groups, with community violence and direct child victimization (child physical and sexual abuse) being associated with improvements in overt and fantasy dissociation. Age and gender played some role as well, suggesting that certain outcomes may be addressed better among children in defined age, gender and exposure history groups. Child depression did not affect outcome as has been noted by others (Runyon et al, 2002), and child factors appear to contribute less to the outcomes after exposure to violence than do the frequency and severity of the violent acts themselves (Kilpatrick & Williams, 1998).

What is it about the group process that seems to improve behavior and emotional symptoms in children exposed to violence? Thorough violence exposure assessment prior to groups appears to uncover sources of trauma and post-traumatic symptoms previously unrecognized by parents and clinicians. This is a key element given that acknowledging trauma is an important first step in treatment (Steele & Raider, 2001). The group process also allows children to then cognitively process and express their feelings in a therapeutic milieu with other children who, while not necessarily having identical violence exposures, have similar trauma symptoms. It is also likely that the structured cognitive experiences provided by trained professionals, coupled with therapeutic drawing and other play activities, provided a unique experience where children can better understand their feelings and learn new responses which improve their behavior and PTS symptoms, although we did not specifically assess the effects of individual components of the group process.

Potential limitations to the applicability of our results to other populations include the high proportion of children being exposed to domestic violence. We had hoped that our inclusion criteria would result in children with a broad range of violence exposures, and we did have children with frequent and severe violence both in and outside of their homes. Given the underlying high prevalence of DV, however, it is hard to conclude whether this intervention will have similar results in populations with limited or no DV exposure. We also have no information about long-term outcomes and no confirmatory information regarding school performance, ongoing mental health treatments, involvement with child protective services or new violence exposures during groups which could have affected completion of the program or helped in our assessment of outcomes. We were also not able to compare the small number of those who did not complete the groups with those that did; this may have biased the results toward including children with better outcomes because of excluding those who dropped out because of dissatisfaction with the groups or who had ongoing family dysfunction. Further research should address the effect of DV and specific program components on specific child outcomes and the long-term effects of the group process, and randomized trials of this and other modalities will be required before we can make definitive statements
recommending groups for all violence exposed children.

**CONCLUSIONS**

Groups for children exposed to violence resulted in clinical improvement in several measures of child behavior and trauma symptoms. While many children improved, boys, those with DV exposure, and younger children had greater gains. Our results are promising and suggest that groups should be considered for children 7-12 years of age with violence exposure and behavior problems regardless of other concurrent medical or emotional diagnoses as it appears that this group process addresses the cause of behaviors and trauma-related symptoms from a variety of sources. While we could demonstrate the feasibility of using these groups in a medical setting, a more definitive recommendation for their use should await further research to demonstrate their effectiveness.

References


Table 1.

"I Feel Better Now" for children ages 6 to 12 years (Steele, 1999)

- Session #1 – This is Me and What Happened
- Session #2 - Fear and Worry
- Session #3 - Hurt and Anger
- Session #4 – Feelings, Safety
- Session #5 - Nightmares
- Session #6 – Reconnecting to the Future
- Session #7 - Parent Participation
- Session #8 – Where to Go From Here, Saying Goodbye
Table 2.

Violence exposure and parent-reported child demographics, symptoms, medical and maternal history

<table>
<thead>
<tr>
<th>Violence Exposure*</th>
<th>Low Violence</th>
<th>High Violence</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number completing groups</td>
<td>28</td>
<td>25</td>
<td>53</td>
</tr>
<tr>
<td>Mean age, y</td>
<td>9.1</td>
<td>8.7</td>
<td>8.9</td>
</tr>
<tr>
<td>Male, %</td>
<td>39.3</td>
<td>48.0</td>
<td>43.4</td>
</tr>
<tr>
<td>Maternal History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abused as child, %</td>
<td>69.2</td>
<td>82.9</td>
<td>75.5</td>
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<tr>
<td>Substance abuse, %</td>
<td>34.6</td>
<td>39.1</td>
<td>36.7</td>
</tr>
<tr>
<td>Medical history</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>ADHD, %</td>
<td>25.0</td>
<td>48.0</td>
<td>35.9</td>
</tr>
<tr>
<td>Asthma, %</td>
<td>14.0</td>
<td>4.0</td>
<td>9.4</td>
</tr>
<tr>
<td>Other Psych Rx, %</td>
<td>14.3</td>
<td>20.0</td>
<td>17.0</td>
</tr>
<tr>
<td>Depression (CDI, mean)</td>
<td>10.3</td>
<td>14.3</td>
<td>12.1</td>
</tr>
<tr>
<td>Violence Exposure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vex-R Score, mean</td>
<td>24.7</td>
<td>28.0</td>
<td>28.7</td>
</tr>
<tr>
<td>Community Violence, %</td>
<td>14.3</td>
<td>36.0</td>
<td>24.5</td>
</tr>
<tr>
<td>Domestic Violence, %</td>
<td>71.4</td>
<td>92.0*</td>
<td>81.1</td>
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<tr>
<td>Child Sexual Abuse, %</td>
<td>0.0</td>
<td>4.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Child Physical Abuse, %</td>
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<td>44.0</td>
<td>34.0</td>
</tr>
<tr>
<td>Symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety, %</td>
<td>42.9</td>
<td>68.0</td>
<td>54.7</td>
</tr>
<tr>
<td>Depression, %</td>
<td>14.3</td>
<td>28.0</td>
<td>20.8</td>
</tr>
<tr>
<td>Anger, %</td>
<td>14.3</td>
<td>44.0*</td>
<td>28.3</td>
</tr>
<tr>
<td>Post-traumatic stress, %</td>
<td>50.0</td>
<td>56.0</td>
<td>52.8</td>
</tr>
<tr>
<td>Dissociation, %</td>
<td>35.7</td>
<td>28.0</td>
<td>32.1</td>
</tr>
<tr>
<td>-Overt, %</td>
<td>46.4</td>
<td>44.0</td>
<td>45.3</td>
</tr>
<tr>
<td>-Fantasy, %</td>
<td>42.9</td>
<td>36.0</td>
<td>39.6</td>
</tr>
</tbody>
</table>

Comparison of high and low violence groups: *P<0.05
*Low Violence = Vex-R < 30; High Violence = Vex-R > 31
**TSCC-A T scores ≥ 60
Table 3.

CBCL and TSCC Scales, pre and post intervention, by violence level

<table>
<thead>
<tr>
<th>Violence Exposure</th>
<th>Low</th>
<th>High</th>
<th>Overall (63)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBCL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalizing</td>
<td>Pre</td>
<td>20.8</td>
<td>18.3</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>10.9</td>
<td>12.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-9.9</td>
<td>-5.9</td>
</tr>
<tr>
<td>Externalizing</td>
<td>Pre</td>
<td>19.4</td>
<td>24.5</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>11.5</td>
<td>18.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-7.9</td>
<td>-6.4</td>
</tr>
<tr>
<td>Total Score</td>
<td>Pre</td>
<td>61.0</td>
<td>69.2</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>34.7</td>
<td>49.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-26.4</td>
<td>-19.5</td>
</tr>
<tr>
<td>TSCC-A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Pre</td>
<td>10.4</td>
<td>13.4</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>6.8</td>
<td>8.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-3.6</td>
<td>-4.6</td>
</tr>
<tr>
<td>Depression</td>
<td>Pre</td>
<td>8.0</td>
<td>10.3</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>4.4</td>
<td>7.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-3.6</td>
<td>-2.8</td>
</tr>
<tr>
<td>Anger</td>
<td>Pre</td>
<td>8.3</td>
<td>11.5</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>5.0</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-3.3</td>
<td>-1.5</td>
</tr>
<tr>
<td>PTS</td>
<td>Pre</td>
<td>14.1</td>
<td>14.9</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>8.8</td>
<td>12.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-5.3</td>
<td>-2.0</td>
</tr>
<tr>
<td>Dissociation</td>
<td>Pre</td>
<td>12.0</td>
<td>10.9</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>7.5</td>
<td>8.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-4.5</td>
<td>-2.6</td>
</tr>
<tr>
<td>Overt Dissociation</td>
<td>Pre</td>
<td>8.5</td>
<td>8.7</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>4.3</td>
<td>5.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-4.2</td>
<td>-3.1</td>
</tr>
<tr>
<td>Fantasy Dissociation</td>
<td>Pre</td>
<td>4.2</td>
<td>4.1</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>3.5</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-0.7</td>
<td></td>
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</tbody>
</table>

*Low Violence = Vex-R < 30; High Violence = Vex-R > 31; Comparison of high and low violence groups: \( ^\text{I}P < 0.05, ^\text{II}P < 0.01 \)
Table 4. Clinical Improvement in Trauma Symptoms*

<table>
<thead>
<tr>
<th>Symptoms (TSCC-A)</th>
<th>Low Violence</th>
<th>High Violence</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety, %</td>
<td>66.7</td>
<td>35.3</td>
<td>48.3</td>
</tr>
<tr>
<td>Depression, %</td>
<td>100</td>
<td>85.7</td>
<td>90.1</td>
</tr>
<tr>
<td>Anger, %</td>
<td>100</td>
<td>54.6</td>
<td>66.7</td>
</tr>
<tr>
<td>Post-traumatic stress, %</td>
<td>85.8</td>
<td>35.7</td>
<td>60.8</td>
</tr>
<tr>
<td>Dissociation, %</td>
<td>70.0</td>
<td>85.4</td>
<td>76.3</td>
</tr>
<tr>
<td>-Overt, %</td>
<td>76.9</td>
<td>82.0</td>
<td>79.2</td>
</tr>
<tr>
<td>-Fantasy, %</td>
<td>50.0</td>
<td>44.4</td>
<td>47.7</td>
</tr>
</tbody>
</table>

Comparison of high and low violence groups: *P<0.05
*Percentage of children changing from T score ≥ 60 to T score < 60.
**Low Violence = Vex-R < 30; High Violence = Vex-R ≥ 31

Table 5.
Regression models for clinical improvement in TSCC-A scales

<table>
<thead>
<tr>
<th>Outcome Scale</th>
<th>Factor*</th>
<th>Odds Ratio</th>
<th>95%CI</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSCC-A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Male</td>
<td>11.4</td>
<td>2.1, 62.1</td>
<td>0.005</td>
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<tr>
<td></td>
<td>Vex-R</td>
<td>0.91</td>
<td>0.83, 0.99</td>
<td>0.033</td>
</tr>
<tr>
<td></td>
<td>DV</td>
<td>23.9</td>
<td>1.46, 392</td>
<td>0.021</td>
</tr>
<tr>
<td>Depression</td>
<td>Male</td>
<td>7.42</td>
<td>1.41, 39.7</td>
<td>0.018</td>
</tr>
<tr>
<td>Anger</td>
<td>NS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTS</td>
<td>Male</td>
<td>5.04</td>
<td>1.15, 22.0</td>
<td>0.032</td>
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<tr>
<td></td>
<td>Vex-R</td>
<td>0.89</td>
<td>0.82, 0.97</td>
<td>0.009</td>
</tr>
<tr>
<td></td>
<td>DV</td>
<td>11.0</td>
<td>1.15, 106</td>
<td>0.037</td>
</tr>
<tr>
<td>Dissociation</td>
<td>AGE</td>
<td>0.51</td>
<td>0.28, 0.91</td>
<td>0.023</td>
</tr>
<tr>
<td></td>
<td>NS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>0.44</td>
<td>0.21, 0.93</td>
<td>0.032</td>
</tr>
</tbody>
</table>

*CV=community violence, CPA=child physical abuse, CSA=child sexual abuse, PsychRx=psych treatment, DV=domestic violence; NS= P>0.05
This book provides the reader a rich background for understanding the effects of trauma on infants and toddlers. Further, it provides an overview of intervention strategies that can be easily integrated into the everyday life of children and families.

This book is a written version of TLC’s online course *Zero to Three: Trauma Intervention*. It is structured to be used as a parent/caregiver education resource and as such it has the following goals: reducing arousal symptoms in both caregivers and children, facilitating secure attachments between children and their primary caregivers and, reducing the incidence of long term effects that trauma can have on young children. The book is written in clear, easily understood language such that some pages can be used as handouts for caregivers.

Each chapter in the *Handbook of Trauma Intervention* provides a short overview of current knowledge on the respective topic. Often this overview is followed by learning activities either for the parent, or the parent and child, to reinforce an understanding of the content. These learning activities serve to stimulate parent thinking or parent/child interaction.

The first two chapters are an overview of the Handbook and an orientation to parent education. Throughout the next two chapters the author explains and illustrates the process of attachment. Mrs. Kuban takes a very profound subject and is able to describe it in a way that parents can understand and discuss. The fifth chapter is an excellent summary of the literature on trauma’s impact on the developing brain. Once again the author takes a very complicated subject and explains it in readily understood concepts and terms. An especially important concept emphasized in this chapter is the negative impact of trauma on nervous system arousal.

The remaining chapters are trauma intervention guides beginning with the mother’s pregnancy, extending through the newborn stage to 36 months of age. These intervention guides provide practical and enjoyable activities that caregivers can easily integrate into the fabric of everyday life. Finally, there is a resource list that addresses all the main topics, a useful glossary and a reference list.

There is no question this book is a “must have” professional resource for those who are beginning to work with very young children/families affected by trauma. Psychologists, social workers, early intervention specialists are excellent audiences for this book.
On April 20, 2007 I listened as Today Show’s Ann Curry interview Virginia Tech student Colin Goddard about his recovery after the college massacre. He had been shot several times and was recovering in the hospital. Twenty plus friends had visited him the previous day. One friend commented “Just being together is the best medicine for us right now. That’s the only way we’ll make it to try to heal each other.” When asked ‘what he needs to recover,” Colin responded he has already begun the healing process. He expressed a strong desire to return to campus to be with friends, and resume his daily routine. I’m ready to laugh. I’m more than ready in my head to move ahead.” His mom affirmed her son’s determination; Colin held his younger sister’s hand throughout the interview.

As I watched and listened to the young survivor’s words I kept thinking about the book I’d just read, The Boy Who Was Raised as a Dog: and Other Stories from a Child Psychiatrist’s Notebook: What Traumatized Children Can Teach Us About Loss, Love, and Healing, by Bruce D. Perry and Maia Szalavitz. This young Virginia Tech survivor corroborated the common thread in each case described by Bruce Perry – that the critical puzzle piece essential for healing from trauma is having a loving supportive network.

The outcome of research on effective treatments to heal traumatized children validates Bruce Perry’s life-work – “that healing and recovery are impossible-even with the best medications and therapy in the world-without lasting, caring connections to others (p. 232).” He takes the reader with him on his journey from starting out as a “new” psychiatrist determined to learn the impact of trauma on children and how to facilitate their healing to sharing his insights and treatment recommendations to facilitate healing.

Perry and his co-author Maia Szalavitz are gifted storytellers. Why are infants and young children at greatest risk of experiencing catastrophic effects of trauma? Through stories of children who have experienced horrific conditions, the reader learns how abuse and neglect wreak havoc with the brain. The courage and determination of the children many of us treat are reflected through story. The authors weave a clear description about the intricacies of the brain into the narrative. I never thought an explanation of the brain and its functions could be so “reader friendly” – especially from a neuroscientist and psychiatrist! By determining which parts of the brain have atrophied due to “lack of use,” Perry creates innovative interventions that stimulate those areas so that normal development can occur.
Perry’s authenticity and compassion reverberate on almost every page. Early on he acknowledges, “I didn’t know squat about abused children.” What he did have at that time was compassion, heart, and common sense. The art of “listening” was also a quality that made such a difference in helping others heal. Throughout the book he refers to a woman who probably had little formal education, but taught Perry the necessity of nurturing to facilitate healing.

I cannot recall being so moved by a nonfiction book – my eyes filling with tears of sadness one moment and then tears of joy and inspiration by the outcomes. Each chapter detailed different cases he treated, sharing his mistakes, lessons learned, and creative innovations he applied. The catalyst for this learning is his early work as a young psychiatrist with a sexually abused child who helped Dr. Perry make the connection between the impact of trauma on the brain and its behavioral manifestations. This taught Dr. Perry the value of allowing a child to reenact their trauma in a safe place. Other chapters included a four year-old misdiagnosed with “infantile anorexia” that Perry brilliantly concluded was “failure to thrive.” Additional chapters include his work with the surviving Branch Davidian children after the offensive by the U.S. government, an interview with a murderer that showed the effect of unintended neglect in early development, and the treatment of a five year-old boy, raised in a cage, who had been misdiagnosed as brain damaged. Every chapter offers the reader so much insight and opportunity for new approaches with “wounded” children.

As I read each page, I reflected on the traumatized children I have worked with in the play therapy setting and I felt validated. Perry emphasizes how children communicate through their art and play. “It is far more difficult for them to hide their true thoughts and feelings in their artwork.” (p. 69). Children must feel safe before any healing can begin. They need to feel accepted, valued and respected before their wounds can start to mend. Restoring hope, restoring their sense of power and control which have been “taken away” are critical. Practitioners must honor the child and let them guide us in the therapeutic interaction.

The implications from this book are many. We do parent as we were parented. Lessons on parenting should start in grade school. Eliana Gil, internationally renowned presenter and prolific writer in the area of abuse, has asked children at treatment termination, what part of the treatment has helped them most. Repeatedly, she shares youngsters comment “her voice and her calm.” Bruce Perry explains that helping another be calm by first being calm oneself is due to the “mirroring neurobiology” of the brain. “To calm a frightened child, you must first calm yourself.” (p. 67)

I recommend this book to anyone and everyone who has contact with children. Bruce Perry’s research and treatment will provide a better understanding of children we are working with. This book should be a prerequisite for all parents caregivers, and professionals.