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I am excited to announce that TLC’s 18 year history of serving traumatized children, families, schools, agencies, and communities will continue for many more years into the future as we enter into a new partnership with a Michigan based non-profit organization.

The intervention programs many of you helped us develop, field-test and support through evidence-based research, the 3000 of you who completed the TLC Certification Program as Trauma Specialists, the estimated 70,000 traumatized children and families you help yearly, the 40,000 professionals who have participated in our conferences and workshops and the hundreds of schools and agencies across the country who have sought our assistance and guidance following critical incidents have all contributed to TLC’s expertise and value in the field of trauma.

And in this regard, I want to now give special thanks to the 500 of you who completed our 2008 survey. Your responses have already been used to support and guide us in our plans of improving and expanding our services to you.

If there is one bit of information that supports the sensory intervention focus TLC has been educating others about for 18 years, it is the following: The defeat of the proposed $700 billion bailout package in the U.S. House of Representatives sent U.S. stocks plunging on Monday, September 29. However, the only stock that finished higher was comfort-food processor Campbell Soup. When asked what Campbell Soup’s secret to success was a spokesperson reported, “We want comfort when we are stressed – chicken noodle soup, tomato soup.”

As we have said, demonstrated, and documented in our research, trauma intervention must first focus on changing the sensory experiences associated with trauma before attempting to engage in cognitive reframing of that experience in a way it can be better managed. Soup really does win out over reason and logic. Not until one is feeling safe and empowered at a sensory level can they then engage critical cognitive processes. This is why TLC has had such successful outcomes.

The recent research using TLC intervention strategies with at-risk and adjudicated adolescents and at-risk traumatized children 7 to 12 years old, clearly supports the value of our interventions. Summaries of these evidence-based outcomes can be found on the web page under the heading titled, “TLC Research Summaries.”

Also in this journal is a summary of the qualitative research we completed. We asked the question, “What allowed some of the children who completed TLC’s I Feel Better Now! intervention program to do better than those who did well but not as well?” These remarkable statistically significant outcomes showing reduction of trauma symptoms and mental health problematic manifestations seen at the beginning of the intervention process provide us the data needed to support future development of our sensory processes, programs and materials.

Speaking of the future, TLC will be 20 years old in 2010. I think because we are constantly attracting new members with rich experiences in trauma who are always eager to share their experiences make us feel as if we have just begun our work. We are still learning so much from everyone associated with us. This is the spirit we will work hard to keep alive for another twenty years. We have begun preliminary discussions of the ways we can celebrate our 20th with all of you, ways we can thank you for helping us have a profound impact on the lives of so many traumatized children and families over the years.

Until then we hope you will continue to give us your feedback, inform us of new programs, and call us for consultations. It is your active involvement that has always been the source of our value and ability to bring you resources that are timely, practical and beneficial to these you work so hard to help.

Thank you for all your support,
Bill Steele
From the Editor

Cathy Malchiodi, PhD [c], ATR-BC, LPCC


The truth about domestic violence is a step toward healing for all survivors. But when talking about violence brings shame, ambivalence, and fear, art therapy gives survivors not only a voice, but also is a way to raise consciousness about the profound effects of battering and all forms of abuse between partners.

While I have no explanation for the psychology behind the current financial crisis, as a therapist I am certain of one psychological effect of an economic downturn -- an increase in domestic violence. In this time of economic uncertainty, job loss, home foreclosures, and increased costs of living, pressures mount in families and frayed tempers inevitably will give way to an increase in battering and abuse. According to the National Domestic Violence Hotline, domestic violence is a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner. Physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person may all be part of the dynamics, including any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure or wound another individual.

While domestic violence can happen to anyone of any race, age, sexual orientation, religion, socioeconomic status, or gender, for the past 25 years I have worked with adult women and child survivors and mostly those who have found refuge in shelters and safe houses. I suspect that with the continuing economic rollercoaster, we will see a rise in not only reports of domestic violence, but also a strain on these community-based programs that help women and children leave abusive relationships.

Although personal safety and a violence-free life are the first and foremost issues for anyone who is the victim of domestic violence, the long term healing process involves recovery from cumulative trauma, often post-traumatic stress reactions, and almost always personal shame and loss of self. Art therapy, which formally began as a field and treatment shortly after World War II, continues to be widely adopted to help battered women and children deal with their physical and emotional scars. Art as a healing force does not come easy for those who lives have been controlled, are accustomed to betrayal and punishment, and have learned self-hatred. But inevitably when it does, creativity and imagination restore a sense of possibility, identity, and reconnection with parts of the self that were silenced in order to survive the violence. While survivors often feel shame in talking about abuse, talking about their artworks is an experience of finally coming home.

The tradition of art as a voice for domestic violence survivors has spawned a number of well-known programs, including the Clothesline Project, a project to address violence against women. In 1990, visual artist Rachel Carey-Harper, inspired by the AIDS quilt, presented the concept of using shirts hanging on a clothesline as a way to raise consciousness. Since doing the laundry was always considered women’s work and women often exchanged infor-
mation over backyard fences while hanging their clothes out to dry, the concept of the clothesline became the vehicle. Each year thousands of women now tell their stories of survival—and commemorate victims who died from domestic violence—by using words and/or artwork to decorate a t-shirt to be exhibited on a clothesline. And programs such as A Window Between Worlds in Venice, CA, serve as models for how art helps both women and children develop a sense of hope, possibility, and safety.

In her seminal volume, Trauma and Recovery, Judith Herman echoes the very reason that violence must be transformed in some way in order for recovery to begin: “Certain violations are too terrible to utter out loud: this is the meaning of the word unspeakable...Atrocities, however, refuse to be buried.” Domestic violence is one of those atrocities that continues to plague lives and for its survivors, is often too horrific to verbalize. Unfortunately, it may increase and intensify in these weeks and months if the expected financial crises continue. And while art is not the panacea for abuse, it is certainly a way through it and one that not only transforms the atrocities of violence, but also sends of powerful message that ultimately breaks the silence.

If you need help, please contact National Domestic Violence Hotline at http://www.ndvh.org/ or phone 1-800-799-SAFE (7233).

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Article

The Intervener’s Relationship with Traumatized Children:
Being a Witness versus Clinician

William Steele, PsyD, MSW

Abstract: The neurology of trauma has clearly documented that trauma is not a cognitive experience but a sensory, implicit experience which drives behavior. If this is accurate it is accurate to say that attempts to help that trauma victim through cognitive interventions alone will have minimal outcomes. The National Institute for Trauma and Loss in Children (TLC) established in 1990 (www.tlcinstitute.org) has developed evidence-based sensory interventions known as SITCAP, Structured Sensory Interventions for Traumatized Children, Adolescents and Parents, which direct themselves at changing the implicit, sensory experience holding trauma victims hostage and in so doing change behaviors and relationships. This article briefly discusses the sensory component of this model which is used in schools and agencies across the country.

The National Institute for Trauma and Loss in Children (TLC) views trauma as a broken, disconnected relationship with life and those in one’s life. In fact in trauma, those who have been in my life during my traumatic experience are likely to continue to activate the intense terror and memories that define my trauma experience. The one word that best describes the experience of grief is sadness, the one word that best describes the experience of trauma is terror and terror is experiencing myself as being unsafe and powerless to do anything about my situation (Steele & Raider, 2001). In this state of terror, relationships become suspect, not to be trusted.

Brendtro, Brohenleg and Van Bockern (1992) define “relationship as an action, not a feeling (p. 76).” Understanding the neurology of trauma we know that trauma refers to an incomplete action, the inability to escape terrifying experiences like violence. In trauma the feeling is one of terror, constantly worrying what will happen next which creates a freeze state, the inability to engage in actions that bring me a renewed sense of empowerment and safety. All I can do while in trauma is constantly be ready (arousal) for the next threat that comes my way. This constant readiness, this chronic fear leads one to frequently over interpret situations, interactions and the presence of danger. It pushes me to engage in basic survival responses; fight, flight, freeze.

Building positive relationships for those living in trauma is very difficult because to do so means I must trust and to trust, “to give someone else power is when I get hurt, when bad things happen.” This is the experience of trauma. It is this experience that drives behavior and that behavior is used for one purpose – to survive what is perceived and often over interpreted to be a “threat to my life.”

If we are asking ourselves “Why does this child continue to engage in the same self defeating, self destructive patterns,” we are not understanding the experience of trauma as engaging in behaviors that in the child’s world and in his view will keep him safe. To truly appreciate or partially understand what is driving a child’s behavior we must first see what that child is now seeing as he looks at himself and the world around him. We must be a witness to how that child is experiencing his life. No diagnostic tool can give us this view. Putting ourselves in the position as a witness

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rather than clinician is the first step in helping traumatized children “reconnect” to a significant other. It is the first step in developing a positive relationship in which avoidance behaviors and the need to control (power) is replaced with respect, caring, generosity and responsibility.

As a trauma intervener, it is essential to accept that we cannot know what that trauma experience is like for a child. It is not our experience, it is the child’s experience, and each child will experience similar incidents differently. This is why it is so important for the intervener to truly be a witness, rather than a clinician in the traditional sense. Being a witness is a method of sitting back and letting the child show us how he is relating to his traumas, to tell his or her story in a way that allows us to learn, at a sensory level, how life is being experienced by the child (Steele & Raider, 2001, pg. 53). Alfred Adler believed that “the specifics of what happens to a person in life are not as crucial as the private logic that a person holds about these events” (Brendtro, Ness & Mitchell, 2001, p. 90). From a trauma informed perspective “private logic” refers to the view the child now has of himself and others in his world as a result of what was experienced as traumatic.

Being a witness supports the fact that trauma is not a cognitive experience but a sensory (non-cognitive) experience. In essence, children frozen in trauma have limited access to cognitive processes and will therefore have difficulty with cognitive based interventions until their sensory experiences or iconic “imprintings” are changed. Most traditional approaches to developing even a therapeutic relationship rely heavily on cognitive processes. Unfortunately to be stuck in trauma means the child is living in and experiencing life in the midbrain, the right hemisphere not in the neocortex, cognitive part of the brain. They are navigating life “implicitly” not “explicitly” (Steele & Malchiodi, 2008, pp. 268-270).

Explicit processes refer to that part of memory sometimes referred to as declarative memory, which processes life events cognitively. In explicit memory we have words to describe what it is we are thinking and feeling, what we like, do not like, want and do not want. We can communicate and express our thoughts as well as take in information and process it in a way that makes sense, in a way that helps us determine what we may need to do (Van Dalen, 2001).

However, trauma is experienced implicitly which refers to how the event is remembered by the body, brain, and central nervous system (van der Kolk, McFarlane & Weisaeth, 1996; Rothschild, 2000; Squire, 1994; Perry, 2007). Our experiences are remembered through our senses; what we saw, heard, the sounds, sights, smells, sensations of touch experienced at the time.

There is no language in implicit memory, no ability to make sense of what is happening. How then do we define our experience, how do we make sense of it all, find a meaning for life that empowers us to thrive not just survive? Our traumatic experiences are defined through an implicit process referred to as iconic symbolization (Michaesus & Baettig, 1996). Iconic symbolization is the process of giving one’s experience a visual identity. Images are created to contain all the elements of that experience. The trauma experience therefore is more easily communicated through imagery (Kaplan, 2000; Malchiodi, 2003; Silver, 2000; Steele & Raider, 2001). Van der Kolk (1998) explained, “When a terrifying incident such as trauma is experienced and does not fit into a contextual memory, a new memory or dissociation is established. (p.289)” “When a memory cannot be linked linguistically into a contextual framework, it remains at a symbolic level, with no words to describe it. The memory must first be retrieved and externalized in its symbolic, iconic form before it can be encoded, given a language, and then integrated into consciousness, also known as explicit memory (Steele, 2003).”

To access children’s implicit memories, interveners must use sensory interventions that allow children the opportunity to present the interveners with their iconic representations and, thereby, make the intervener a witness to their experiences. Such interventions give the intervener the opportunity to see how the child now sees himself and his world after experiencing trauma.

Positive, enriching relationships, especially with those living implicitly with little access to cognitive explicit processes, can be developed through sensory experiences individuals engage in with one another. When these sensory experiences allow each to feel safe as well as empowered, the emotional, behavioral and cog-
nitive difficulties induced by their traumatic experiences will diminish (Steele, W., Kuban, C. & Raider, M., 2008-2009, pending publication). Through trauma specific sensory-based activities developed by TLC, research demonstrates that the iconic trauma imprinting that life is dangerous will change, arousal reactions and the chronic state of fear will diminish and be replaced by the iconic, sensory experience that life is not to be feared but embraced. It is at this point that behavior changes and in fact cognitive, explicit processes can now be engaged for more effective solution focused processes. In essence, children begin to reclaim their lives with a new view of self, others, and life, a view not as a victim but as a survivor and thriver empowered by choice. This cannot come about through cognitive interventions alone.

One brief example of incorporating sensory activities designed to restore a sense of safety and power followed by behavioral changes is that of a 12-year-old girl in a residential setting. Having been exposed to multiple traumas of abuse and abandonment, Alice (fictitious name) became a “runner and biter”. Prior to being trauma informed, these behaviors were identified by staff as severe problematic behaviors and punished by the withdrawal of privileges and restrictions when they occurred.

Those responsible for her care were asked to adopt a trauma view of her behaviors as very understandable, survival behaviors when she was activated or aroused by situations in her environment or by interactions with others that triggered past iconic memories leading her to believe that “bad things” were going to happen to her all over again. She was not running away, but engaging in an activity to escape from what she believed to be threatening. She was trying to run to a place where she could be safe – the flight response. When things happened so quickly that she couldn’t run she attacked, started biting – the fight response.

Once staff understood that the child’s trauma history made it difficult for her to follow directions much less process many of their cognitive attempts to intervene, they began to think (emotional intelligence) of appropriate sensory activities, which could be used to restore this child’s sense of safety and power. They engaged her in a few practice runs and pre planned with designated staff their calming, protective interactions with this child when she arrived. Over the next month the youngster ran multiple times to her safe adults/staff. Once calmed (no restraints or seclusions) her safe persons walked her back to her residence staying with her for a few minutes during her transition. The last three months of her stay there were no additional episodes. She began to self regulate her reactions and could do so because the actions and behaviors of staff were no longer reactive, controlling or punitive but protective, engaging and comforting. Behavior changed when the interactions with the child changed.

The end result of this sensory-based intervention was the “new relationship” she developed with staff and staff with her. Both diminished their arousal responses and behaviors making room for her to now trust adults differently and consequently reestablish her connection to her family. It was the “action” of staff not reason, logic or cognitive attempts to control this child’s behavior that replaced her trauma related iconic memories with sensory memories of safety, empowerment and trust.

In summary, the nature of a relationship is defined by the nature of the interactions between those in that relationship. In trauma, the interactions must be at a sensory level, and directed at the way that individual is experiencing himself, others and the world around him as a result of his traumatic experience. These trauma associated sensory experiences must then be challenged by directed sensory activities, which bring relief from the terror of those memories as well as reestablish a renewed sense of safety and power. Once this is accomplished it is far easier for a “reconnecting” to now experience safe, empowering adults. This renewed sense of safety, connectedness and empowerment readies the child to then embrace new opportunities, which enrich his view of self and value to others. (For further information about the sensory, evidence-based intervention programs developed by The National Institute for Trauma and Loss in Children – TLC, go to www.tlcinstitute.org)

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Do educators and schools have an informed role to play in the lives of students struggling with unprocessed traumatic memories other than providing cognitive learning experiences? Although schools are not mental health facilities and teachers are not therapists, teaching today’s students requires alternative strategies and skills compared to what worked a generation ago.

The correlation between trauma and low academic achievement is very strong and relevant. [Perry, 2004; Schore, 2001; Stein & Kendall, 2004] With the current extraordinary focus on test scores, educators are missing a significant information-base directed toward learning successes along with a reduction in behavioral outbursts and drop-outs.

Schools have attempted to address learning and behavioral dilemmas repeatedly over the last decade with traditional educational strategies and minimal success, focusing on what actually are symptoms of traumatic stress as opposed to the root cause, which is trauma itself, has not resulted in the desired outcomes for students or schools. The field of education, from preschool through teacher training, cannot ignore the issue of traumatic stress if schools are to meet the expectations of parents, community, and the nation.

Becoming a trauma informed school goes beyond identifying and referring students with traumatic stress to outside services; taking a passive role will not bring about the steps necessary to assure every student will meet their full potential. [Perry, 2004]. Improving academic achievement in rural, suburban, and urban schools requires educators examine the cross-disciplinary research of neurobiological research and traumatology.

Understanding Altered Brain Development

Changes in society, employment, entertainment, and family have contributed to changes in early childhood experiences of many students which has resulted in altered brain development and traumatic stress. [Schore, 2001; Siegel, 2007; Solomon & Siegel, 2004]. Effectively teaching today’s students requires alternative techniques and school policies in order for the school to meet academic expectations. Electronic imaging techniques clearly illustrate that brain structure and chemistry is altered for children who are anxious, insecure, and have experienced uncompleted attachments.

Attachment Trauma

Children who have not been afforded the opportunity to complete the attachment process during early childhood have reduced capacities for self-regulation, stress management, and empathy, according to Allan Schore. [2001] Early relationships that are predictable, soothing, and include ample eye contact, smiling faces, and touching, stimulate critical development in the prefrontal cortex, considered the executive manager of the neurological system. Perceived rejections and separations will continue to be a sensitive issue for these children and youth if not addressed by informed adults, especially in the elementary grades. [Bailey, 2000; Stein & Kendall, 2004; Badenoch, 2008].

Children with an underdeveloped pre-frontal cortex...
often present disruptive and unsettling behaviors in early elementary classrooms due to separation distress and not having the neurological structure necessary for self-regulation. Unfortunately, these behaviors can be misinterpreted as misbehaviors, not stress behaviors, and are reacted to with disciplinary actions. Such reactions, in turn, are then interpreted by the child as another rejection, setting in motion a pattern of emotional insecurity and behavioral issues that greatly interfere with learning for the rest of the student’s education.

Implicit memories from early infancy of angry or frustrated faces remain encoded in their amygdale unless processed and externalized. [Badenoch, 2008] Whenever the child, later as a student, sees the same facial expression on a staff member, that same sense of rejection and shame is generated, only the student has absolutely no awareness of the reason why the internal anxiety has arisen. Those implicit memories were encoded without narrative and are now not available to the student cognitively. Such experiences can result in social and relationship patterns that become lifelong struggles for children who were denied the opportunity to attach. [Colozino, 2006]

Having Experienced or Witnessed Chronic Violence

Natural disaster, accidents, and other single incidents of distress can traumatize a child but the chronic stress of family or community violence or abuse will have the most lasting effect on the child’s brain.

Early childhood experiences of fear and terror tend to be recorded without words or narrative. These implicit memories are stored in the amygdale, deep within the limbic area of the brain and cause perceptions of helplessness along with over-sensitized fear-alarm reactions whenever the child or youth perceives a threat. [Colozino, 2006; Oehlberg, 2006] Such fear reactions, even in school, are prompted by an automatic shift out of the neo-cortex into the limbic area for survival purposes of fight, flight, or freeze. [Perry, 2004; Levine & Kline, 2007]

These survival reactions, generated by unprocessed memories of terror and loss, directly complicate learning and classroom climates. These students are not able to communicate their sense of fear and doom with words but do so through behavioral out-bursts and class disruptions. Unfortunately, such behaviors can be interpreted by uninformed adults as disrespect and defiance; even as ADHD. Normal disciplinary actions that may follow will result in the student continued processing out of the limbic system and not the neo-cortex. Students cannot learn or problem-solve when not in the neo-cortex. [Forbes & Post, 2006]

Students with traumatic stress pay particular attention to teachers or school personnel who are beginning to lose control, indicated by a changed breathing pattern, facial expression, and tone of voice. These cues will trigger perceptions of vulnerability for students with unprocessed traumatic memories. Such survival reactions by students following a perceived threat are neither rational or by choice as they are not generated by the central nervous system and neo-cortex; neither are they acceptable. They are sensory reactions generated by the limbic system and appear to be anger rather than fear. Anxious student’s need for emotional security at such times will go farther in reinstating a classroom climate beneficial to learning than shame or threats [Forbes & Post, 2006].

One student’s fear-alarm reaction can trigger and spread to other students with unprocessed traumatic stress, creating a classroom climate in which little learning ensues. [Oehlberg, 2006; Dallmann-Jones, 2006] Trauma sensitive student’s ability to learn is further compromised by their inability to focus and stay on task.

At the other end of the behavioral spectrum, traumatized students may present dissociation and appear very numb, passive, and frequent daydreaming in class. Although these students may not upset classroom climate, they are not actively engaged in cognitive learning as they struggle with internal static and confusion. Bruce D. Perry states that these students hear about half the words spoken by their teachers, causing them to fall behind year after year [Perry, 2004].

Traumatized students are unable to problem-solve or participate in their own safety after they have downshifted out of their neo-cortex when threatened. Regretfully, this sense of helplessness can prompt some teens to be more afraid of life than of death, making them exceedingly difficult to motivate in the classroom.
Being Trauma Informed: What it Means

Integrating trauma sensitivity into the educational system constitutes a paradigm shift but with minimal costs. The information on how brain development is altered because of early childhood insecurities has stunning implications for school policies and teaching techniques. It counters most of the assumptions about misbehaviors wall of us heard in our respective child -hoods and throughout our professional education. Despite these challenges to our understandings, becoming a trauma informed school affords significant benefits to staff and students.

- **Administrative commitment**: Integration of trauma sensitivity begins with the administration by clearly endorsing that all students will be safe inside the school, on the school grounds, and on the busses. The framework of total security, primarily emotional security, will become the primary focus in all situations and actions by students and staff. The power of relationships will be acknowledged and practiced, with every student being assigned a staff member in a caring supportive team relationship. Building a school climate of respect and generosity of spirit by all can be initiated only by administration.

- **Disciplinary policy**: Traditional disciplinary policies and protocols tend to aggravate the sense of rejection by offending students who have a traumatic history. Such policies generate a sense of internal shame that has been encoded since early childhood. A trauma informed policy is built on the premise that infractions are generated by insecurities and fears, not anger or by choice. Instead of punishments, the focus will be on ways to restoring the offending student to the school community. [Amstutz & Mullet, 2005; Oehlberg, 2006; Forbes & Post, 2006]

- **Staff development**: In-services on brain development and trauma will be presented to all staff; teaching, non-teaching, and volunteers. Particular attention will be given to the sensitivity of students with traumatic stress to the body language, non-verbal communications, and use of threats by staff. Bullying and shaming by adults will not be tolerated as it re-traumatizes students. Included in these in-services will be bus drivers, security personnel, office staff, cafeteria staff, tutors, volunteer playground and hall monitors. Teachers will be introduced to classroom sensory activities for externalizing and transforming unprocessed memories of helplessness that fit into core curriculum subjects.

- **Counselors, school psychologists, and serving mental health specialists serving the school**: Screening and assessment tools that indicate traumatic experiences, past and present, will be introduced and used, not just identifying symptoms. Interventions will be encouraged. Relationships with trauma-specific mental health providers in the community will be developed.

- **Students**: Information on the human brain and its development will be introduced sensitively into health classes, including survival adaptations and resiliency requirements. Student CARE Teams will be encouraged at the high school level to meaningfully connect with and support those students who are not fully integrated into the school community [Perry, 2006].

**Benefits for Being a Trauma Informed School**

- Improved academic achievement and test scores.
- Improved school climate.
- Improved teacher sense of satisfaction and safety in being a teacher.
- Improved retention of new teachers.
- Reduction of student behavioral out-burst and referrals to the office.
- Reduction of stress for staff and students.
- Reduction in absences, detentions, and suspensions.
- Reduction in student bullying and harassment.
- Reduction in the need for special educational services/classes.
- Reduction in drop-outs.

At a time when schools and teachers are exceedingly stressed and stretched, becoming trauma informed may seem an ambitious and challenging strategy. However, the rewards for everyone involved are real and energizing.

TLC will be offering an internet course in Jan. 2009, featuring strategies that could be used by counselors, mental health professional, and other dedicated persons to facilitate a school becoming trauma informed. ◆
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Article

Connections, Continuity, Dignity, Opportunities Model: Follow-up of Children Who Completed the I Feel Better Now! Trauma Treatment Program

William Steele, PsyD, Melvyn C. Raider, PhD, Caelan Kuban, LMSW

Abstract: This qualitative study illustrates the resilience and posttraumatic growth characteristics (PTG) that were present and distinguish those children who showed the greatest improvement and sustained gains after completion of the I Feel Better Now! Program compared to children who demonstrated the least improvement. The children who saw and sustained the greatest gains had an overall greater percentage of resilience and PTG characteristics cited in the literature. The study indicates that those who had fewer gains would therefore benefit from further interventions focused on characteristics such as connections, continuity, dignity, and opportunities, and activities that support resilience and PTG.

Keywords: trauma, resilience, posttraumatic growth, children, intervention

Introduction

The purpose of this article is to answer a prominent question raised during the randomized, controlled research study, Children of Today: Short-term Interventions, Long-term Gains, conducted with at-risk, traumatized children 6-12 years old in four elementary schools in Taylor, Michigan (a core metropolitan city near Detroit). As a group, children participating in this school-based trauma intervention program, I Feel Better Now! demonstrated statistically significant (p < .001) reduction in many trauma-related symptoms and reactions upon program completion. These gains were sustained through the 3 and 6-month follow-up period. The question we asked was related to resilience and posttraumatic growth (PTG). We wanted to attempt to determine what characteristics were present and distinguish those children who showed the greatest improvement and sustained gains after completion of the I Feel Better Now! program compared to children who demonstrated the least improvement?

The I Feel Better Now! program is based upon The National Institute for Trauma and Loss in Children’s (TLC Institute) SITCAP (Structured Sensory Interventions for Traumatized Children Adolescents and Parents) model, a comprehensive, evidence-based, sen-

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sory trauma intervention approach designed to diminish the cognitive, behavioral and emotional symptoms that traumatized children, adolescents and parents can experience following a trauma (Steele & Raider, 2001). In this model, symptom reduction and the restoration of safety and empowerment are accomplished through a series of sensory based activities related to the major experiences of trauma, which thereafter supports cognitive processes associated with survivor/thriver experiences of trauma, which thereafter supports cognitive processes associated with survivor/thriver thinking versus victim thinking. Based upon the current neuroscience documentation that trauma is not a frontal cortex (cognitive) experience but a sensory, implicit one (Levine & Kline, 2008; Perry & Szalavitz, 2006; van der Kolk, 2006), interventions are focused initially on sensory-implicit activities associated with the major experiences of trauma. Following these activities SITCAP is also designed to achieve the successful cognitive re-ordering of traumatic experiences in ways that move traumatized individuals 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 such as in the SITCAP model, the child has a greater chance of benefiting from intervention that addresses the maladaptive coping behaviors characteristic of children who have experienced trauma reactions. In this model, trauma reactions are normalized and the distinction between trauma and grief is emphasized. This structured model provides a session-by-session, situa\tion specific (e.g., school vs. agency) guide to trauma intervention. It is appropriate for individuals who have experienced violent or non-violent trauma and is age-specific (preschoolers, 6-12 year olds, adolescents, adults). Focusing on themes such as safety, hurt, worry, fear, anger and revenge that often result after experiencing either violent or non-violent types of trauma, enhances the generalizability of the model. The parent component of SITCAP encourages a supportive caregiver response and addresses past and present trauma in the parent’s life (Steele and Raider, 2001).

The original randomized controlled study was conducted at four elementary schools in the Taylor School District, Eureka Heights, Fisher, Taylor Parks, and Myers Elementary Schools in 2nd through 5th grade. Parent’s whose child experienced or witnessed one or more traumatic events as indicated on TLC Institute’s Traumatic Incident Life Event Checklist granted permission for their child to be screened for severity of trauma symptoms. The Briere Trauma Symptom Child Checklist (TSCC) was used as the screening tool. All children with an elevated score (within the clinical range) in one of the subscales on the TSCC were randomly assigned to either Group A, the treatment group, which participated in the ten-week I Feel Better Now! Program, or Group B, the wait list or control group. After the ten-week waiting period children and parents in Group B participated in the 10-week I Feel Better Now! Program, identical to Group A. Three standardized trauma and mental health measures, the TLC PTSD Child and Adolescent Questionnaire (CAQ), the Briere TSCC and Achenbach’s Child Behavior Checklist (CBCL) were administered at pre-intervention, post-intervention, 3-month and 6-month follow-up. Children and parents in Group B completed an additional set of measures at the end of their wait list period. Children demonstrated statistically significant (p < .001) reductions in trauma symptoms across subscales of re-experiencing, avoidance, and arousal and reductions across mental health subscales including depression, somatic complaints, social problems, thought problems, attention problems, internalizing and externalizing problems, rule breaking behavior and aggressive behavior.

It was hypothesized that those who saw and sustained the greatest gains had a greater percentage of resilience and PTG characteristics cited in the literature. Focus groups with all participants were conducted to determine the presence and/or absence of these characteristics in those who did well versus those who did well but not as well. The study also hoped to identify other possible characteristics supporting resiliency not cited in the literature.

**Resilience**

Resilience characteristics have been reported to exist in children prior to trauma experience (Bonanno, Papa and O’Neill, 2001). Children who demonstrate most of the psychological and emotional attributes associated with resilience and whose social and family environment supports resiliency may experience trauma symptoms after exposure to traumatic events however, only a small number will develop posttraumatic stress disorder (PTSD). Psychological and emotional attributes associated with resilience in children include; above average verbal skills, cognitive and problem solving abilities, positive self-esteem, ability to self-regulate behavior, positive expectations about the future, the ability to ask for help and to use social support.
Family and social environmental processes associated with resiliency include; a stable, nurturing parent/caregiver, a connection to an adult in the extended family and consistent family processes such as rituals, routines, traditions and structure (Cloitre, et al, 2005; Rice & Groves, 2005). In describing their Connections, Continuity, Dignity, Opportunity (CCDO) model Sieta, Mitchell and Tobin (2001) wrote that resilience was the outcome of environments that “promote connections, continuity, dignity and opportunity” (p. 106). Connections refer to supportive, guiding, positive relationships. Continuity refers to events that shape one’s life. Dignity refers to value for self (self worth) and others, and opportunity refers to environments that foster growth and change. Of course, not all resilient children possess all of these attributes nor do all of these attributes exist to the same degree in children. It is therefore, reasonable to hypothesize that factors of resilience exist in several combinations and psychological and emotional attributes exist to a greater or lesser extent in children. Family and social environmental supports range from many to modest and it is reasonable to assume that a child with several psychological, emotional, family and social attributes associated with resilience may be most resilient. Children with fewer psychological, emotional, family and social attributes may be less resilient. Consequently exposure to traumatic events may result in fairly rapid return to pre-trauma functioning for children at the high end of the continuum of resilience and more prolonged struggle with posttraumatic symptoms for less resilient children.

**Posttraumatic Growth**

PTG is the outcome of successful use of specific coping skills following exposure to trauma (Ungerleider, 2003). Reworking the trauma experience leading to a new contextual framework or trauma narrative that becomes manageable is essential for PTG to occur. This is not necessarily the case in resilience as the “pre-existing framework” about self may prevent the need to rework the experience. PTG is a relatively new concept and is manifested in several clearly defined behavior and thought patterns not necessarily present prior to exposure, as are resiliency characteristics (Turner & Cox, 2004). Tedeschi & Calhoun (1996) developed a PTG growth inventory of 21 items that evaluates characteristics of PTG including; relationships with others take on greater value, new possibilities become more clearly defined, personal strength and empowerment supports one’s belief in the ability to make changes, an overall enhanced appreciation of life is developed (Tedeschi, Park & Clahoun, 2000). Turner and Cox (2004) described similar characteristics of PTG including willpower and altered perspectives as the two primary descriptors. Chesler (2003) defines PTG as the experience or expression of positive life change as an outcome of a trauma or life crisis. The Circle of Courage model developed by Brendtro, Brokenleg and VanBrockern (1990) suggests children do best when they experience belonging, mastery, independence and generosity. These we suggest are outcomes of a series of experiences described under resilience under the CCDO model of connections, continuity, dignity and opportunities. There are a number of authors that cite the following psychological emotional, and behavioral changes as indicative of PTG; feeling more compassion and empathy for others, increased psychological and emotional maturity in comparison to peers, increased ability to “bounce-back”, deeper understanding of personal values, purpose and meaning, taking control of one’s recovery, and the ability to reframe one’s trauma experience (Tedeschi & Calhoun, 2004; Ungerleider, 2003; Turner & Cox, 2004; Steele & Kuban, 2008). Pathways to PTG therefore involve changing the sensory experience of trauma then reframing that experience into a trauma narrative that can be managed and thereafter followed by actions or experiences that support this new view of self, others and life.

To summarize, there are many similarities between resilience and PTG such as taking control of one’s choices associated with resilience and taking control of one’s recovery associated with PTG. Resourcefulness associated with resilience is also similar to accepting help associated with PTG, as are “connections” and “belonging”, “mastery” and “independence”. The literature, as well, cites many differently defined characteristics. In some cases these characteristics are outcomes resulting from adhering to specific beliefs, values, and behaviors.

Given the variety of descriptors for resilience and PTG it was determined that the characteristics could be included under the CCDO cited categories of connections, continuity, dignity and opportunities. This study sought then to identify specific characteristics within
the categories that could be attributed to those who saw the greatest gains compared to those who saw fewer gains.

**The Qualitative Study: Child, Parent, and Social Worker Focus Groups**

Child, parent and social worker focus groups were held upon completion of the 6-month follow-up period of *I Feel Better Now!* program. The "top one third" of children, were those who had the best results across all evaluation measures after completing the program. Similarly, the "bottom one third" of students were those who had the least amount of improvement. Fourteen students from the top one third and 13 students from the bottom one third were selected to participate in these focus groups. These groups were then randomly assigned as follows: Group One into two groups of 7 students (Group 1A, Group 1B) and Group Two into one group of 6 students and a second group of 7 students (Group 2A, Group 2B).

The Taylor Schools’ Director of Social Work invited the selected parents and students to attend the focus groups. Parents and students were invited by a mailed letter and then by follow-up phone call. Each parent and each student received dinner at the focus group sessions as well as a gift card used as compensation for participation in the focus groups. Meijer gift cards in the amount of 25 dollars for parents and 5 dollars for children were provided. Parent groups (60 minutes) included two groups of parents from students in the highest rate of improvement group and two parent groups from students in the lowest rate of improvement group. There were four total parent groups. Student groups (45 minutes) consisted of four total student groups of six to seven participants each (two groups from the highest rate of improvement group and two groups from the lowest rate of improvement group). Children and parents were asked focus group questions supported by sensory-based activities contained in a guide given to each child and parent. They were asked to respond to questions verbally. Every child and parent focus group was transcribed verbatim by a court reporter. Taylor School Social Workers served as facilitators and co-facilitators for each parent and student focus group.

Additionally, there was one focus group conducted with the Taylor Schools social workers that lead the *I Feel Better Now!* program groups in the original study.

The social work focus group (90 minutes) consisted of 8 social workers, was led by the TLC Institute and took place at the Taylor Schools Administration Building. This group utilized guides containing questions and supporting activities. Social workers were asked to respond to questions verbally. This focus group was also transcribed verbatim by a court reporter.

**Demographics of Children in Focus Groups**

Children in the focus groups were an average of 10 years old, were predominately white (86%) and all (100%) had histories of multiple traumas including both violent and non-violent trauma exposures such as abuse, neglect, domestic violence, death of a parent, witness to neighborhood violence, separation and homelessness. All (100%) of focus group child participants had additional life events during the follow-up period. These additional life events also consisted of violent and non-violent trauma. The differences therefore in the children in focus groups who showed most improvement as compared to children in focus groups who showed least improvement were not in race, age, life events or trauma history.

**Focus Group Observations**

The following tables illustrate the most significant differences in responses between those who saw the greatest gains versus those who saw the least gains. Both groups for example reported having fewer nightmares, not being as jumpy and nervous, having less anger and laughing more. The responses represent the response of the majority in each group. Group A represents the children with the greatest gains and Group B represents the children with the least gains.

If we simply read the different responses of the two groups of children to questions about their parents we see a much better quality of interaction between children and parents of the group who saw the most gains not seen in the group who saw fewer gains.

The children who saw fewer gains clearly indicated the absence of support from their parent/caregiver. Furthermore those who saw the greatest gains report very specific interactions with parents, compared to those who saw fewer gains being unable to describe specific helping interactions. This also suggests that a very limited sense of connection and belonging exists for these children. We might hypothesize that these children do not see themselves as being valued as...
much as the children who saw the greatest gains. This is supported in Table Two and later in Table Six.

The children who saw the greatest gains reported far more verbal affirmations. Those who saw fewer gains only reported the one affirmation, “I love you” whereas the majority in this group reported, “They buy me things” versus providing multiple verbal affirmations. Connections via verbal interactions were limited among those who saw fewer gains. Also the quality of interaction that does exist is less self-enhancing and self-esteem building. Saying “I love you” is not the same as “You make me laugh” and “You are smart.”

The fact that the children who saw fewer gains did not specifically identify a parent, teacher or another adult being important, readily supports the absence of human connection. Having a connection with someone other than a parent was cited as a resilience factor in the literature. A few of the responses from Group B further illustrate this absence. “My grandma, but she is dead.” “I don’t know – myself?” “My parents, they have to take care of me”. Not only are these children not being “treated special” they are void of feeling really important to somebody.

Children who lack connection will alienate themselves and engage in avoidant behaviors. Not knowing and experiencing valued connections, they will find it difficult and threatening to trust or engage others and explore new activities. These children will have fewer peers who like them, will be less likely to seek help and less likely to talk to others about their difficulties all of which are substantiated in Tables Five and Six.

As connections and interactions are limited at home they will be limited outside the home. This was also supported by the observations of the social workers. We see in Table Six the children with fewer gains interact with others in ways their parents interact with them. Seeking help and having value for others were identified as factors of PTG. Although both groups engage these factors, we see that those with fewer gains only sometimes engage or initiate these and other factors. Sometimes

Parents
The majority of parents of the children who saw the greatest gains were employed and had health insurance. Most were able to take their children special places. Most had computers and parents monitored their use. The children of this group therefore had greater opportunities for growth. Many of the parents whose children saw fewer gains were receiving public assistance, had histories of drug abuse, unsteady employment, were parents with mental illness, parents working afternoons, had no medical insurance, had no computers, unable to afford to put children in outside of school activities such as Little League and Boy Scouts. This group overall had fewer opportunities for growth and mastery. These comparisons make it quite clear that family resources play a significant role in allowing children to make significant gains following trauma intervention.

Parents also provided their observations (Table Seven) of the differences seen in their children following completion of the program.

First we see that parents of both groups had similar observations of changes experienced in their children following completion of the program. However what distinguishes the two groups is that children who saw the greatest gains demonstrated higher levels of self-esteem (value for self) were empathetic to others (value for others) and almost all were observed to be more self-expressive and open with their feelings. However, those who lived in environments where interactions/connections, continuity, dignity and opportunity were limited realized fewer gains.

Conclusion
The fact that all participants sustained gains six months following completion of the I Feel Better Now! program suggests they all shared characteristics of resilience and PTG.

The majority of participants reported (Table Seven) fewer nightmares, sleeping better, less anger, less arguments, not as jumpy or nervous and laughing more. The question is whether those who saw the greatest gains also experienced additional characteristics not present in those who did less well? The answer is yes.

The interaction between parents and the children who had fewer gains was severely limited. For example, there was very limited verbal affirmation from parents reported by those children. Those who saw the great-
est gains cited multiple affirmations coming from their parents while only one affirmation; “I love you” was reported by the children of fewer gains. Saying “I love you” does not carry the same value as “You make me laugh” or “You are smart” which were examples reported by children with the greatest gains. Children obviously need to hear how they are valued to feel valued. It is not surprising that only 65% improvement in self-esteem was reported by parents of the children with fewer gains compared to 86% improvement reported by those with the greatest gains.

Furthermore, if a child has little value for himself, he will have little value for others. This is supported in both parent and social worker observations of the child’s interaction with others as only sometimes being empathetic. Dignity (self-worth, respect for others) was reported as minimal therefore among those with fewer gains. Subsequently if a child has little value for self or others, he will not likely ask for help nor be “more open with feelings.” Of those who saw the greatest gains 93% reported their children were more open their feelings and always sought help as needed compared to 50% among those with fewer gains. The quality of interactions between child and parent certainly represents a focus for future interventions for those who had fewer gains.

Connections for those with fewer gains were also limited. The children who had the greatest gains were connected to an adult other than their parent and reported having many friends in the neighborhood and at school. We saw that the children with the greatest gains played with friends “all day on the weekend and during the summer” compared to the lesser gain children who reported far fewer friends and limited or no significant contact with adults other than parents. These children also reported they played “only 2-3 hours a week with friends”. These same children also participated less in group activities and were less liked by their peers. School staff, when reporting their observations, were unaware of which children had greatest or least gains yet their observations of those who had fewest interactions with peers was of those who had fewer gains.

Somewhat related to the area of connections as well as opportunities and dignity was the fact those who saw the greatest gains more frequently reported that “going to class” was one of their favorite things about school. Those with fewer gains did not mention going to class as one of their fun things to do, instead they cited gym and recess. When a child questions his own identity, has limited opportunities for growth and who has not experienced positive interactions with parents on a regular basis will become terrified of the opportunities which class presents.

The quality of “continuity” (event’s that shape one’s life) for these children’s lives was definitely different. Those with the greatest gains reported a home life that was fairly predictable, one in which there were frequent interactions with parents, a wide range of fun things to do, strong verbal affirmations and traditions (i.e. Friday Night movies). It was the opposite experience for those with fewer gains. Verbal affirmations were limited, fun things to do were infrequent (My favorite thing to do at home is sleep). As these children reported about their various aspects of home life they presented a picture of often being lonely and bored. They reported very minimal experiences, which brought them joy compared to those who saw the greatest gains.

The use of the CCDO model helped describe the differences between the two groups of children and emerged as more useful than attempting to cite the many and varied characteristics of resilience and PTG cited in the literature. Certainly those who saw the greatest gains tended to have stable, nurturing parent connections, connected to adults other than their parent, had social support, and compassion for others. At the same time those who had fewer gains also shared these characteristics but not at the level of quality, or frequency reported by those with greatest gains.

The I Feel Better Now! Program demonstrated its value for the children with fewer gains as well as those with greater gains. Even given differences between the two groups, gains once obtained were largely sustained six months after completion of the program. However, those who had fewer gains would likely be far more vulnerable to experiencing their difficult life events as traumatic and begin to see fewer sustained gains without further interventions focused on connections, continuity, dignity and opportunities and activities which support these as manifestations of resilience and PTG. Given the finding of this study the I Feel Better Now! program will be accompanied by an additional program for those similar to the children and their lives.
who had fewer gains. The program, *Raising Resilient Children in a Traumatic World: A How to for all Parents and Teachers* will be a school based program to assist parents and families engage in and practice supporting greater resilience and PTG in their children.

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**Table One**

<table>
<thead>
<tr>
<th>Group A Greatest Gains</th>
<th>Group B Least Gains</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much have your parents helped you feel better?</td>
<td>“Not at all”, “A little bit”</td>
</tr>
<tr>
<td>“A lot”</td>
<td></td>
</tr>
<tr>
<td>How did they help to feel better?</td>
<td>“Do not help at all”</td>
</tr>
<tr>
<td>“Spending time together”</td>
<td>(Majority were unable to say how they helped)</td>
</tr>
<tr>
<td>“Helping with homework”</td>
<td></td>
</tr>
<tr>
<td>“Playing games together”</td>
<td></td>
</tr>
</tbody>
</table>

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**Table Two**

<table>
<thead>
<tr>
<th>Group A Greatest Gains</th>
<th>Group B Least Gains</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are some things your parents say that make you feel good about yourself?</td>
<td>“They buy me things”</td>
</tr>
<tr>
<td>“I love you”</td>
<td>They say,” I love you”</td>
</tr>
<tr>
<td>“You make me laugh”</td>
<td></td>
</tr>
<tr>
<td>“You are smart”</td>
<td></td>
</tr>
<tr>
<td>“They ask if I’m okay”</td>
<td></td>
</tr>
</tbody>
</table>

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**Table Three**

<table>
<thead>
<tr>
<th>Group A Greatest Gains</th>
<th>Group B Least Gains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is most important to you and what makes you like them best?</td>
<td>“I don’t know”</td>
</tr>
<tr>
<td>“Parent/Caregiver/Grandparent/Uncle”</td>
<td>“They buy me things”</td>
</tr>
<tr>
<td>“They treat me special”</td>
<td></td>
</tr>
<tr>
<td>“We play games on the weekend”</td>
<td></td>
</tr>
</tbody>
</table>

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**Table Four**

<table>
<thead>
<tr>
<th>Group A Greatest Gains</th>
<th>Group B Least Gains</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your favorite thing to do at home?</td>
<td>“Sleep”</td>
</tr>
<tr>
<td>“Spend time with parents, brothers, sisters”</td>
<td></td>
</tr>
</tbody>
</table>
### Table Five

<table>
<thead>
<tr>
<th>Group A Greatest Gains</th>
<th>Group B Least Gains</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How often do you play with your friends?</strong></td>
<td><strong>&quot;We play all day on the weekends and during the summer.&quot;</strong></td>
</tr>
</tbody>
</table>

### Table Six

<table>
<thead>
<tr>
<th>Social Worker Observations</th>
<th>Group A Greatest Improvement</th>
<th>Group B Least Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive self-identity</td>
<td>Always, Most often</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Positive coping skills</td>
<td>Always</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Empathetic to others</td>
<td>Always, Most often</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Able to articulate feelings</td>
<td>Most often</td>
<td>Sometimes, Not at all</td>
</tr>
<tr>
<td>Participates in groups</td>
<td>Most Often</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Has an aspect of life that gives them joy</td>
<td>Always</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Child is like by peers</td>
<td>Most Often</td>
<td>Sometimes, Not at all</td>
</tr>
<tr>
<td>Child is liked by school staff</td>
<td>Always, Most Often</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Seeks help</td>
<td>Always</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Talks about problems</td>
<td>Most Often</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>

### Table Seven

<table>
<thead>
<tr>
<th>Parent Observations</th>
<th>Group A Greatest Gains</th>
<th>Group B Least Gains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved Self-esteem</td>
<td>86%</td>
<td>64%</td>
</tr>
<tr>
<td>Child talks more, more open with feelings</td>
<td>93%</td>
<td>50%</td>
</tr>
<tr>
<td>Sleeping better</td>
<td>71%</td>
<td>64%</td>
</tr>
<tr>
<td>No more nightmares</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Less Anger</td>
<td>71%</td>
<td>71%</td>
</tr>
<tr>
<td>Less Arguments</td>
<td>71%</td>
<td>64%</td>
</tr>
<tr>
<td>Better Grades</td>
<td>64%</td>
<td>50%</td>
</tr>
<tr>
<td>Not as nervous, jumpy, anxious</td>
<td>71%</td>
<td>64%</td>
</tr>
<tr>
<td>Laughs more</td>
<td>71%</td>
<td>71%</td>
</tr>
</tbody>
</table>
References


