

## APPENDIX I

### GROUP DYNAMICS (PROCESS) FACTORS IN SMALL GROUPS

- I. Individual personalities in interaction (interdependence between group and individuals; interpersonal influence)
- II. Group boundaries (leader-member; member-member; in-group: out-group)
- III. Leadership (persons attracting attention and wielding influence; formal and informal)
- IV. Cohesiveness (forces acting on members to remain in the group; group's attraction to members)
- V. Role differentiation (role choice; role assignment; role “suction”)
- VI. Patterns of communication (cognitive; emotional; verbal; nonverbal)
- VII. Emotional relations (sociometric attractions, repulsions or indifference)
- VIII. Norms (culture; rules)
- IX. Climate (democratic; laissez-faire; authoritarian)
- X. Values (beliefs; myths)
- XI. Stages of group development
- XII. Subgroupings

## APPENDIX II

### THERAPEUTIC GROUP FACTORS (BLOCH & CROUCH, 1985; YALOM, 1994)

- I. Acceptance (sense of belonging; being accepted and valued by group and/or individuals; “holding environment”)
  - II. Universality (“being in same boat;” “we are all in this together;” “my problems are not unique)
  - III. Catharsis (ventilation of feelings; emotional release)
  - IV. Corrective emotional experience (reliving earlier dysphoric emotional states with better outcomes)
  - V. Family transferences (parents; siblings, group-as-a-whole)
  - VI. Modeling (emulation; identification with therapist and/or peers)
  - VII. Reality testing (correcting misperceptions)
  - VIII. Learning from interpersonal interactions (“feedback” regarding one’s behavior and its impact on others)
  - IX. Vicarious learning (experiencing through empathic identification with others)
  - X. Insight (“meaning attribution”; interpersonal, intrapsychic, genetic)
  - XI. Help from peers (altruism)
  - XII. Guidance (imparting of information)
  - XIII. Instillation of hope (countering demoralization) (Bloch & Crouch, 1985; Yalom, 1994)
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Note 1: Therapeutic Group Factors are differentiated from “conditions for change” and “therapeutic techniques” and defined as assumed “...processes occurring in group therapy that contribute to the improvement of the patient’s condition and are regarded as a function of the actions of the therapist, the other members of the group and the patient himself” (Bloch, Crouch & Reibstein, 1981).

Note 2: Some or all of these factors can operate together on conscious and/or unconscious levels; i.e., “dynamic-contemporaneous” and “genetic-regressive” levels (Scheidlinger, 1982)

From: Scheidlinger, S. (1997), Group dynamics and group psychotherapy revisited: Four decades later. *International Journal of Group Psychotherapy*, 47:141-159.

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## APPENDIX III

### TALKING WITH OUR CHILDREN ABOUT TRAUMATIC EVENTS

As we begin to recover from the shock and horror of the tragedy that took place on September 11, many people will start to reflect on the deeper meaning of such events. Our children, in particular, may seek explanations to try and help put these tragic events into perspective.

How do we talk with and comfort our children about these situations? Following are some guidelines from national experts that may help you communicate with your children about these recent events.

I. Get a clear picture. Don't bring the topic of September 11 up proactively; wait for your children to ask about it. When they do, get a clear picture of your child's understanding by asking your child what he or she understands about the recent events and their meaning. This will help you gauge your child's level of understanding and help you decide how much or how little information you want to discuss.

II. Listen carefully. Listen to your children, paying close attention to their emotional signals as well as their words. Children may often say one thing but their body language can reveal more than first meets the eye. It's important to listen carefully so you can correct any misperceptions, and paint a clear picture for your child. Make sure your child knows she/he can ask questions and be receptive to his/her needs. By being active listeners, parents can determine how much stress or worry their child may be experiencing.

III. Adjust your response to the child's need. After you've determined their level of understanding, distress and needs, respond in an age-appropriate manner to questions and concerns. Sometimes, just reassurance that parents are safe is all that is needed. Other times, a more detailed explanation may be called for.

IV. Assure your child that he or she is safe. It is critical to communicate to your children that they are safe and that as parents, we do everything possible to keep them safe. Explain and make sure they understand this.

V. Give your perspective. Older children and adolescents will look for your personal perspective on the events, which helps them form their own values and beliefs system. The recent attacks have shed light on our beliefs about politics, religion, prejudice and even the use of violence to resolve situations.

## APPENDIX IV

### PRINCIPLES OF CLINICAL WORK WITH TRAUMATIZED CHILDREN

I. **DO NOT BE AFRAID TO TALK ABOUT THE TRAUMATIC EVENT.** Children do not benefit from not thinking about it or putting it out of their minds. If a child senses that his/her caretakers are upset about the event, they will not bring it up. In the long run, this only makes the child's recovery more difficult. Don't bring it up on your own, but when the child brings it up, don't avoid discussion, listen to the child, answer questions, provide comfort and support, We often have no good verbal explanations, but listening and not avoiding or over-reacting to the subject and then comforting the child will have a critical and long-lasting positive effect.

II. **PROVIDE A CONSISTENT, PREDICTABLE PATTERN FOR THE DAY.** Make sure the child knows the pattern. When the day includes new or different activities, tell the child beforehand and explain why this day's pattern is different. Don't underestimate how important it is for children to know that their caretakers are in control. It is frightening for traumatized children (who are sensitive to control) to sense that the people caring for them are, themselves, disorganized, confused and anxious. There is no expectation of perfection, however, when caretakers are overwhelmed, irritable or anxious, simply help the child understand why, and that these reactions are normal and will pass.

III. **BE NURTURING, COMFORTING AND AFFECTIONATE, BUT BE SURE THAT THIS IS IN AN APPROPRIATE CONTEXT.** For children traumatized by physical or sexual abuse, intimacy is often associated with confusion, pain, fear and abandonment. Providing hugs, kisses and other physical comfort to younger children is very important. A good working principle for this is to provide this for the child when he/she seeks it. When the child walks over and touches, return in kind. The child will want to be held or rocked- go ahead. On the other hand, try not to interrupt the child's play or other free activities by grabbing them and holding them.

Do not tell or command them to "give me a kiss" or "give me a hug". Abused children often take commands very seriously. It reinforces a very malignant association linking intimacy/physical comfort with power (which is inherent in a caretaking adult's command to "hug me").

I. **DISCUSS YOUR EXPECTATIONS FOR BEHAVIOR AND YOUR STYLE OF DISCIPLINE WITH THE CHILD.** Make sure that there are clear rules and consequences for breaking the rules. Make sure that both you and the, child understand beforehand the specific consequences for compliant and non-compliant behaviors. Be consistent when applying consequences. Use flexibility in consequences to illustrate reason and understanding. Utilize positive reinforcement and rewards. Avoid physical discipline.

II. **TALK WITH THE CHILD.** Give them age appropriate information. The more the child knows about who, what, where, why and how the adult world works, the easier it is to reassure them.