

GROUP INTERVENTIONS FOR TREATMENT OF PSYCHOLOGICAL TRAUMA

MODULE 2: GROUP INTERVENTIONS FOR TREATMENT OF TRAUMA IN CHILDREN

By

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Since then at an uncertain hour that agony returns: And 'til my ghastly tale is told, this heart within me burns.

S.T. Coleridge, The Rime of the Ancient Mariner

Both the cause and the cure of trauma related psychological disturbances depend fundamentally on the severity of interpersonal attachments.

van der Volk, B.A., Psychological Trauma

I. INTRODUCTION AND OBJECTIVES

In a uniquely foresighted move, the Girl Scouts of America, an organization with more than two million members, created a new achievement badge for "learning to identify and handle stressful situations." This was done in a realization that even before the September 11th tragedy, there had been ample evidence, in line with the so-called "body-mind connection," that all undue stress constitutes a hazard to people's body and to their psyche. While the body's immune system and organ stability can thus be compromised, a person's psychological equilibrium via its anxiety and mood levels, can also suffer. In other words, being prepared for stressful situations serves as a protector against traumatic reactions from the unknown.

Given children's well-known fragility in their sense of self and in their related extreme dependence on adults for constant support and security (i.e., Winnicott's "holding environment"[1965]), they are especially prone to dysfunctional reactions to even minor life stressors. Major natural or man-made traumas are, accordingly, bound to exact truly serious consequences on children's functioning and on their sense of well-being.

The effect of severe disasters on children has received increased attention in connection with the unprecedented September 11th terrorist attacks in New York City and in Washington, D.C. Prior to that, this subject had emerged to public scrutiny on a much smaller scale in relation to natural disasters, such as hurricanes or floods, as well as human acts of violence, as exemplified by the Chowville, California, bus hijacking, the Oklahoma City bombing, and the Columbine High School violence. The mental health literature that dealt with therapeutic interventions related to these events focused on large-scale and on dyadic measures. There were thus descriptions of school assemblies, of classroom discussions and of dyadic counseling sessions (James, 1989). Small group (face-to-face) approaches were rarely featured. This module is designed to redeem this lack.

II. THE CONCEPT OF TRAUMA AS APPLIED TO CHILDREN

A. Childhood trauma has been defined by Terr (1991) as "...the mental result of one sudden external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations" (p. 11). The internal change thus provoked can be temporary, or last for years.

B. Terr noted, furthermore, that children's traumas entailed the following four major characteristics:

1. Strongly visualized or otherwise repeatedly perceived memories;
2. Repetitive behaviors which symbolized the trauma;
3. Trauma-specific fears;
4. Changed attitudes about people, about aspects of life, and about the future.

C. Thus, tied up with children's well-known fantasy world can be omens—private, usually irrational explanations of why the traumatic event occurred. With it may go a sense of having been, in some way, responsible for the episode. (Such feelings are especially common in instances of parental death.)

III. THE PSYCHIATRIC CLASSIFICATIONS OF CHILDREN'S TRAUMA

A. The Diagnostic and Statistical Manual of Mental Disorders, DSM IV (1994) refers to three related yet distinct kinds of children's reactions to traumas:

1. Adjustment Disorder which involves the emergence of emotional or behavioral symptoms in response to some identifiable stress. If these symptoms last less than six months, they have been termed acute, if longer, they become known as chronic. Adjustment Disorders can be characterized by the nature of symptomatology, i.e., depressive mood, anxiety or conduct disturbances.

2. Acute Stress Disorder represents a condition that came about due to a particularly traumatic event that entailed bodily injury including the threat of death. In addition to fear, to helplessness and to agitated behavior, this diagnostic category can present dissociative symptoms, amnesia, numbing and detachment. The most severe reaction to trauma resides in the diagnosis of PTSD.

3. Posttraumatic Stress Disorder (PTSD), where coupled with extreme anxiety and feelings of helplessness, child PTSD sufferers can display three categories of symptom clusters:

- a. Re-experiencing (i.e., nightmares; repetitive re-enactments in talk or in play;
- b. Avoidance or numbness (i.e., refusal to fly or to enter tall buildings after September 11th),
- c. Hyper-arousal (i.e., sleeping difficulties, problems in concentration, hyper-vigilance).

B. Research has suggested additional co-morbidity factors wherein, in addition to the above-noted diagnostic categories, affected children can display depression and crystallized phobias; among the latter, separation anxiety as well as school refusal. In this connection, in places such as India, Northern Ireland and Israel where random, long-term terrorism has persisted, many children developed what was termed a "continuous traumatic stress syndrome." As might be expected, pre-disaster risk factors, such as earlier stresses, physical or mental disabilities, as well as the severity of a given trauma, can make some individuals more susceptible to marked posttraumatic reactions. Conversely, a favorable environment (i.e., support systems) and a child's natural resilience (i.e., good coping skills) are likely to work as protectors.

IV. THE CHILDREN IMPACTED BY THE SEPTEMBER 11TH CATASTROPHE

A. There appears to have been four categories of psychological child-victims in this event.

1. Children who, like most New Yorkers or Washingtonians, were "in town" and were exposed to the day-long screeching sirens of rescue vehicles, coupled with the media's constant "bombardments" with details of the disaster. These contained gruesome portrayals of New York's collapsing towers with people jumping to their deaths, of hectic relief efforts, climaxed by a frantic crowd, which included Mayor Giuliani, running to escape the toxic dust clouds.

2. Children from nearby homes or schools who actually witnessed these horrid happenings.

3. Children who have lost parents, siblings or acquaintances in the catastrophe.

4. Children whose families have suffered economically as a consequence of the attack. Each of these categories call for special understanding and intervention.

B. After six months of the September 11, 2001 tragedy, 10.5% of New York City's school children still suffered significant posttraumatic stress symptoms. These included, thinking obsessively about the event, trying not to think, hear or talk about it, sleeping problems and nightmares, as well as shortened attention spans, (*New York Times*, May 2002).

C. As for the earlier bombing in Oklahoma City, where 168 people lost their lives, including 19 children, with about 250 children left orphaned, almost one year after the tragedy, nearly 5% of elementary school-age children reported marked PTSD symptomatology.

D. Not unlike the New York City findings, girls were more prone to noxious effects than boys. (In New York, this was especially true with Hispanic girls.) Significantly, exposure to gruesome television portrayals emerged as a greater risk factor, than personal witnessing.

E. In this connection, it is important to note that regretfully, the currently available trauma-related assessment scales are of limited value (Ohan, Meyers, Collett, 2002).

V. CHILD DEVELOPMENTAL CONSIDERATIONS IN TRAUMA

While most adults are bound to display some untoward reactions to traumas, such as the September 11th tragedy, for children, the challenge is much greater. Unable to make sense of international events, inexperienced in coping with major anxieties, and looking for orientation and strength from their elders who may themselves be emotionally shaken, traumatized children may have the very foundation of their world rocked.

Since infants are uniquely sensitive to adult mood states, they need, on such occasions, more than the usual open expressions of affection and of physical touch. We have learned from World War II's London Blitz, that the physical presence of parents and the latter's emotional stability are primary requirements, notwithstanding the raw dangers of war. Accordingly, nowadays, even brief separations as well as the well-known, anxiety-laden bedtimes, call for special attention and patience from adults. When toddlers and pre-schoolers ask questions, they need verbal reassurances that their parents and their known social networks, are here to protect them. For example, they may need to be told that while there are "bad guys" out there, our army and police are on constant guard. Such brief responses are in order because pre-schoolers, while grimly aware of threatening events, are not likely to understand them. Hearing adults talk about such happenings are bound to make young children feel insecure, adding to their frightening imagery provoked by television displays of actual violence. The best way to assess what is on the minds of pre-schoolers is to follow their play. They appear to be gnawed by an underlying worry that "something might happen to me and to those I love and need."

As for elementary school-aged children, given their difficulty in separating fantasy from reality, it is important to let them tell you first through their play, their drawings and questions, what they think about and fear, before you intervene. Elementary school-aged children know more and imagine more than what we adults think. While lacking perspective, they nevertheless understand dangers and evil for what they are. They fear that what they had seen and heard happening to people can happen to them. We are reminded of a 10 year-old girl's poignant drawing of the burning World Trade Center's towers, with a falling child's yelling, "I don't want to die." Building on such youth's characteristic natural concerns with rules and with issues of right and wrong, they need adult help in differentiating between perpetrators and victims, between the guilty and the innocent.

VI. PROFESSIONAL INTERVENTIONS WITH TRAUMATIZED CHILDREN

A. In contrast to the substantial literature on posttraumatic interventions with adults, there has been little written on such work with children, especially in connection with outside of the home disasters.

B. The following three basic first aid phases employed by the American Red Cross with adults hold for children as well.

1. Pre-impact, impact and recoil
2. Post-impact
3. Recovery and reconstruction

C. With trauma-induced disorders, early and effective interventions in the post-impact phase are likely to prevent the development of the more severe conditions such as Posttraumatic Stress Disorder (Litz, Gray, Bryant & Adler, 2002).

1. As for the so-called, usually single debriefing or defusing sessions, which are a part of psychological first aid and which rely primarily on catharsis alone, these are not only counter-productive, but can even be harmful.

2. This was particularly true with the post-September 11 work by some well-meaning artists in schools, where they were content with children's raw emotional artistic productions of fear and of pain without accompanying steps of "working through," designed to lead toward positive cognitive reconstruction and toward a sense of mastery (Mitchell, 1983).

D. Clinical experience, to date, has underscored the value of multi-faceted interventions in the case of large-scale disasters that have involved children, directly (Lystad, 1988). Thus, in the Chowville, California, school bus hijacking or in the more recent incidents of school violence, mental health professionals conducted school-wide meetings with students, with teaching staff and with parents. Initial, large-group debriefing, clarification, mourning and support meetings, were then followed by individual and by small-group counseling sessions, where more intensive interventions were indicated. Special tests and behavioral observations were employed, to identify those in need of longer-term services.

E. When viewed from the perspective of an individual child victim, therapeutic intervention is designed to lead the traumatized child toward appropriate coping resources, i.e., to the steps and to the means which will aid to modify his or her self-systems by reducing or eliminating the detrimental effects of the trauma and to restore the earlier ability to function in life.

F. In contrast to reconstructive psychotherapy, which aims at personality reorganization with the challenging of defenses, the aim here is more circumscribed, i.e., the elimination of dysfunctional behavior.

G. In some instances, long-term deeper involvement is indicated as with a child who was the sole survivor of his family in the Holocaust, or of a six-year-old girl who had witnessed the murder of her mother by her drunken father.

VII. SMALL GROUP INTERVENTIONS WITH PSYCHOLOGICALLY IMPAIRED CHILDREN

A. The use of face-to-face groups with children for therapeutic purposes has a long history. The first such therapy groups were begun in the late 1930s in the United States by S.R. Slavson, an erstwhile progressive school teacher turned lay psychoanalyst.

1. The rationale for activity therapy groups (Slavson, 1943) was based on children's developmental responsiveness to group experiences and to the latter's important role in the building of an individual sense of identity and of self-esteem (Grunebaum & Solomon, 1989).
 2. These group approaches were welcomed by the then child therapists who had been challenged by the difficulty involved in eliciting verbal communication and introspection in so-called "latency-age" children, in a one-to-one context.
 3. Activity group therapy stresses the free expression of feelings and of fantasies through action, through manual activities and through play.
- B. A permissive, family-like environment with an accepting adult in charge promotes a benign regression aimed at the evocation of the inner child, akin to a corrective emotional experience. The interaction of the children with each other and with the therapist, constitute the prime therapeutic ingredients.
- C. Activity group therapy emerged as a valuable intervention modality for mildly disturbed youths when used alone, or in combination with individual or family treatment.
- D. As more seriously impaired children and especially markedly impulsive ones appeared in clinics (i.e., so-called conduct disorders or borderline personality patients), Slavson's original treatment model had to be revised, introducing more structure and verbal interventions (Scheidlinger, 1960; Frank, 1976).
1. The above-depicted children's psychotherapy groups constitute a clinical modality applied by specially trained mental health professionals working with carefully balanced groups, with each child-patient having been judged as being suitable for group treatment on the basis of a diagnostic assessment.
 2. Such groups designed to repair diagnosed personality pathology in clinical settings, need to be differentiated from the myriads of psychoeducational and support groups for children, employed in social agencies and in schools.
 3. The issue here is not whether any one category of helping groups is superior to any other, but rather to maintain their differences in the interest of conceptual clarity.
- E. The field of children's group treatment contains a variety of theoretical models, ranging from the oldest psychodynamic one, to more recent cognitive-behavioral approaches (Slavson & Schiffer, 1975; Lomonaco, Scheidlinger, & Aronson, 2000). While this was at first considered to be controversial, most of children's groups nowadays entail the serving of snacks because of their realistic and symbolic value (Scheidlinger, 1982).

VIII. CRISIS INTERVENTION AND SUPPORT GROUPS

A. Short-term group approaches have come into being in connection with the treatment of traumatized children.

B. In conceptual terms, the earlier-cited reconstructive group therapies were replaced by problem-centered, time-limited groups, with a primary stress on coping, on adaptation, on competency and on strength.

C. Crisis Intervention Groups were mentioned earlier when employed as a part of a community or school-wide design in offering first aid to a large traumatized child population in the face of natural or human-made disasters (i.e., hurricanes or school violence).

1. In such situations, ad hoc groups comprised children of similar age who have been affected by the traumatic event, such as the sudden death of a teacher or of a student.

2. After brief introductions and of minimal efforts to establish at least a degree of connectedness (i.e., a feeling of being at one with the shock and pain), group discussions were focused on the reality of the event (what actually had happened), followed by the appropriate expressions of feelings of loss and of mourning.

3. While the number of sessions was geared to the expressed need, the group interventions were usually concluded with some kind of an act of resolution via memorial ceremonies and other concrete or symbolic gestures.

4. As might be expected, the door was left open for additional counseling, as needed.

D. Support Groups are designed to offer emotional support to children who are facing a common problem or handicap.

1. In contrast to the necessarily ad hoc Crisis Intervention Groups, they can be planned with greater care and offered for larger periods of time.

2. They derive their special motivational power from the fact that they are homogeneous and contain a shared sense of being in the same boat, with empathically linked fellow sufferers.

3. The concept of children's Support Groups arose from the mushrooming self-help group movement for adults, with its stress on voluntary participation in striving for mutually agreed upon goals (Dumont, 1974).

4. The currently most popular Support Groups are those for children of divorce and for physically or sexually abused ones.

E. Groups for Children of Divorce

1. Groups for Children of Divorce are usually sponsored by clinics or by schools.
2. As suggested by Cantor (1977) and by Kalter, Pickar & Lesowitz (1984), they are geared to:
 - a. Normalize the sense of being a child of divorce;
 - b. Clarify the confusing and stressful divorce issues;
 - c. Provide a safe setting to express and to deal with conflicted feelings;
 - d. Develop appropriate coping strategies;
 - e. Share the children's concerns about the parents.
3. In the course of their group work, these authors discerned the need for more group time to help the children deal with such additional stresses of post-divorce living, as problems with parental visitations, as well as those raised by the parents' new partners.

F. Groups for Abused Children

1. Groups for Abused Children are generally conducted in clinical settings.
2. They are initiated so as to prevent the well-known, profound symptomatology and personality changes subsequent to children's being victimized by trusted adults. If left untreated, life-long problems in trust, in interpersonal relations and in sexual behavior have been observed.
3. Mandell & Damon (1989) produced a workbook for the group treatment of sexually abused children. A concrete, step-by-step progression aims to help the victims to identify and to express their conflicted feelings. Fostering of healthy social skills and of ways to deal with adults in the future are included.
4. Kitchur & Bell (1989) reviewed the relevant literature and offered short-term group interventions structured around a weekly theme.
5. Gilbert (1988) used developmental play therapy groups for work with younger, sexually abused children. These sessions included educational content, which covered, among others, the important issue of "good touch" versus "bad touch," by adults.

a. In play therapy, the traumatized young child (about 4-8 years old), not unlike his older peers had done with words, can be helped to re-live and to correct the pain and misperceptions from past experiences through the medium of play.

b. The latter constitutes the child's language for describing his subjective experience.

c. It is the analogue of the patient-therapist communication with adults. In addition to the more obvious value of doll house, soldier, doctor figures or puppets, there are also meaningful self-disclosures afoot when a child reacts with feeling, to winning or losing in a game of checkers or to an emotionally charged story or film strip.

d. In the hands of skillful therapists, play can serve as a channel for the working through of painful experiences, of anticipated fears, coupled with constructive adaptation.

6. Children's play therapy has a long history in the psychoanalytic camp with such distinguished pioneers as Anna Freud and Melanie Klein (Bretherton, 1984). While the latter work was dyadic in nature, Ginnott (1961) and Schiffer (1960) had devised models for play group therapy.

7. In a recent publication, Chazan (2002) elaborated in depth on the varied components of children's play, such as:

a. Affective (love-hate);

b. Cognitive (person-objects);

c. Narrative (story);

d. Developmental (baby-child-adult).

8. Returning to group work with older, traumatized children, Rice-Smith (1993) depicted a comprehensive intervention program for sexually abused youths, built around the following six, graduated phases.

a. Acknowledgement

b. Stabilization

c. Uncovering

d. Mastery

- e. Integration
- f. Transformation

9. There is encouraging research support for the value of short-term group interventions with child-victims of sexual abuse (Kitchur & Bell, 1989).

10. Given the unique opportunities offered by the group medium such as universality, normative peer support, interpersonal feedback, reduced isolation and enhanced self-esteem, group interventions have come to be viewed as the treatment of choice for these problems (Knitte & Twana, 1980; Finkelhor, 1986).

IX. CHILDREN'S BEREAVEMENT GROUPS

A. Not unlike the instances of parental divorce, there is convincing evidence for the noxious results of parental or close family member's death on children's functioning. As noted by Berlinsky & Biller (1982), such youths showed increased chances for delinquency, dependent personality patterns, introversion, suicidal ideations and undue preoccupation with issues of loss.

B. Furthermore, clinicians reported immediate reactive behaviors in bereaved children such as:

- 1. Anger;
- 2. Clinging, coupled with separation anxiety;
- 3. Denial;
- 4. Nightmares;
- 5. Regression in toilet habits.

C. While most of the literature has centered on the individual treatment of such children, there has gradually emerged increased interest in the use of the group modality for bereaved children, often in combination with individual contacts. The majority of the reported group intervention models share the following sequential framework:

- 1. Getting acquainted;
- 2. Building group cohesiveness based on the shared affliction;
- 3. Each child's relationship to the deceased;
- 4. Feelings about the funeral and other means of saying "good-bye;"

5. Anticipated changes occasioned by the loss;
6. Looking to the future and termination of the group.

D. Notwithstanding the above-listed commonalities, practitioners have adopted a variety of techniques designed to achieve these same purposes. Accordingly, Masterman & Reams (1988) reported on an eight-session program comprising a co-leader team and designed for bereaved pre-schoolers and school-age children, respectively. The sessions for pre-schoolers were less structured and entailed a group with no more than five children aged from three to six.

1. Each child was invited to bring a favorite toy to the session, and to introduce it to the group.
2. This was followed by an interchange about the toys.
3. There then ensued a 15-minute free play period with toy ambulances, figures of medical personnel, and a hearse.
4. The workers distilled from this play, relevant personal themes such as anger, fear, magical rescues, feelings of powerlessness and of guilt.
5. In addition, the adults initiated stories and puppet plays aimed at eliciting additional themes, where indicated.
6. Accordingly, the authors introduced the following story designed to help the children deal with the ever-present guilt feelings in relation to a parental death.

E. The Story

Once upon a time, in a meadow where the sun was shining on some days and on other days it was cloudy, there lived a kid squirrel named Rupert. Rupert lived with only his Mom, because his Dad had died. Rupert felt a lot of different feelings after his Dad's death. There was this one feeling that Rupert had thought maybe he had helped his Dad to die.

You see, on the day before his Dad had died, Rupert had done something bad and his Dad had yelled at him, and then the next day his Dad had died. So Rupert thought, "If I had been a good squirrel, maybe my Dad wouldn't have died."

When Rupert thought this he felt very bad because he loved his Dad and wanted him alive again, and didn't want to have hurt his Dad. One day when Rupert was thinking about how maybe he had helped his Dad to die and was crying, his Mom saw him and she said:

- M: I miss Daddy, too. It feels bad that Daddy died.
R: If I'm a really good boy, can Daddy be alive again?
M: No. We both would really like Daddy to be alive again, but once a person is dead, they stay dead and there is nothing we can do to make them alive.

R: I wish I had been a good boy before, then Daddy would still be alive.
M: What do you mean?
R: I was a bad boy and then Dad died and I caused it.
M: No, Rupert, you didn't make your Dad die. Even if you had been good the night before, your Dad would still have died. You didn't kill him.
R: But he always yelled at me to be good, and then I was bad and angry at him, and he died.
M: That's not how it works. A child can't make a parent die by being bad or by feeling angry at him. Your Dad was killed by being sick, not by you.
R: O.K. Mom, I guess I did not cause Dad's dying, but I still wish Dad was alive.
M: I wish Dad was alive, too, but he still is going to be dead and we can't make him alive, and we didn't kill him.

Rupert's Mom was right. Kids don't make their parents die. Sometimes kids think that if they had done something different, then their Mom or Dad would still be alive, but that's not true. Kids can't make their parent dead. As mentioned earlier in the discussion of play therapy for younger children, the overall therapeutic aims evolved around a continuous search for diagnostic indicators regarding individual children's specific concerns and misperceptions, which still needed to be addressed.

F. In the same program, the larger, eight-member groups for elementary school-age children, used discussions rather than play as the basic medium for communication. Within the total number of eight sessions, each week had a pre-announced theme.

Week 1:	The group's purpose, rules and get acquainted activities.
Week 2:	Self-disclosures about the circumstances of the parent's demise.
Week 3:	Exploration of feelings including the family's involvement in the last rites.
Week 4:	Changes in the family and in its network, occasioned by the death.
Week 5:	Coping with the loss, i.e., denial, anger, wishes, religious beliefs, guilt.
Week 6:	Concerns and plans for the future.
Week 7:	Feelings about the group's termination and ideas for future supports.
Week 8:	Closing rituals and plans for staying in touch.

G. This model differs in some respects from other similar ones described in the literature by featuring less than the most common 12 sessions and in calling also for homework assignments, family genograms and letters to the deceased. Most importantly, it utilized "Little Red School House" (mixed ages), instead of the more popular practice of similar age groups. In one other program, there was stress on the children's bringing relevant photographs and other memorabilia from the deceased to the sessions, on an active involvement of the surviving parent, and on the use of a box for anonymous questions for the more inhibited group members (Fleming & Balmer, 1991).

H. MacLennan (1998) stressed the special value of mourning groups for inner-city youths where there are so many unnecessary deaths from AIDS, from family, and from drug-related violence.

I. A detailed process summary of such a bereavement group for inner-city youths is offered by Keyser, Seelans & Kahn (2000).

J. Groups for Children of Alcoholic Families

Groups for Children of Alcoholic Families are a recent development, as research revealed that children of alcoholics have a high risk of becoming alcoholic, or of marrying someone who is an alcoholic.

1. The children's groups offer a supportive environment to explore and to share feelings related to the usual family secret, as well as to learn how to trust and to talk openly about the real issues.

2. Providing information about alcoholism and repairing strained family relationships are major goals (Bingham & Bargar, 1985; Hawley & Brown, 1981).

3. The most comprehensive overview of group interventions for children of alcoholics has been provided by Dies & Burghardt (1991).

K. Groups for Medically Ill Children

Coping and adapting to chronic and to severe illnesses are especially trying for children and for their caretakers. The supportive group process lends itself well to promote a readier acceptance of the handicap and facilitates cooperation with the required medical procedures.

1. Group methods have been used for a gamut of ailments ranging from kidney disease through diabetes, to allergies (Dubo, 1951).

2. Flanagan (1983) described a group approach for children with cancer.

3. In distinction from such homogeneous groups, Williams & Backer (1983) outlined a short-term, structured heterogeneous group for children with a variety of chronic illnesses. The sessions included factual information about the different diseases, with discussions about feelings and reactions to medical personnel as well as to the parents.

4. Open-ended groups have also been developed on pediatric wards with stress on the expression of fears, the correction of anxieties and of distortions, provision of factual information, and, above all, companionship and mutual support (Woodruff, 1957; Cofer & Nir, 1975).

X. GROUP THERAPIST QUALIFICATIONS, FUNCTIONS AND COUNTERTRANSFERENCE

A. As elaborated by Rosenthal (1977), a trained child group worker understands the basic concepts of group formation and dynamics operative in all children's groups, and couples this awareness with knowledge of the specific therapeutic factors in group interventions.

B. The major group therapist function applicable to trauma-focused groups include the following:

1. An individual preparatory session, if possible, to allow for a final screening, for the correcting of misconceptions about the group experience, and to establish a beginning therapeutic alliance;
2. Developing group rules with a focus on the creation of a safe, accepting group climate (holding environment);
3. Empathic acceptance and caring for each child, coupled with a belief in the latter's potentiality for change;
4. Encouragement for the open expression of feelings and concerns regarding the experienced trauma;
5. Fostering a climate of tolerance and acceptance for variance in feelings and behaviors (discourage pressure toward conformity);
6. Controlling the tension and anxiety level in individual group members within acceptable limits
7. Controlling group-level manifestations (i.e., bullying, scapegoating, monopolizing, instigating) in the interest of an optimum state of group morale;
8. Verbal interventions via simple observations, confrontations and explanations.
9. Introduction of appropriate techniques, i.e., role playing, picture-slides, readings or puppets, as indicated.

C. Countertransference in trauma work has been defined by Ziegler & McEvoy (2000) as containing "all of the trauma therapists' responses to the client, to the client's story, and the client's behavior, as well as the concerns and unconscious defenses mobilized by the therapist to protect her from these reactions" (p. 117).

D. In addition to the usual countertransference reactions, linked to all group work with children (Azima, 1986), there are those additional ones evoked by the subject of trauma. Among them:

1. Overwhelming feelings of horror, disgust and of pity;
2. Denial and minimization;
3. Over-identifications and rescue fantasies;
4. Extreme reactions toward perpetrators;

5. Doubts about the therapist's ability to contain the massive impact of the noxious emotion.

E. In the instance of post-September 11th traumatization, workers have found it especially difficult to depersonalize the feelings of having been victimized together with the traumatized children. With it goes the anxiety inherent in the general expectations of additional attacks. For terrorism constitutes an extreme form of trauma as it impacts not only on its direct victims, but also their human networks, from family to community with an acute sense of personal vulnerability.

F. Co-therapy can serve as a support system for the helpers.

G. Ongoing supervision is a virtual must in trauma-focused groups (Schamess, Streider, & Connors, 1979).

XI. THE INVOLVEMENT OF PARENTS AND OF CARETAKERS

A. The very notion of child therapy entails a steady and in-depth involvement of the parents in this process.

B. Because of the almost symbiotic ties between caretakers and children, parents of traumatized children need help in understanding the nature of the child's dysfunction and their role in aiding the therapeutic regimen.

C. With it goes their need for support in dealing with their own myriad of anxieties, as well as with having a traumatized child.

D. They also need to observe the children's behavior, which the helpers need in assessing the progress of their work.

E. Parents have accordingly been seen in individual counseling sessions as well as in groups. The latter ran, at times, in tandem with the children's groups. There is an extensive literature on such work (Arnold, Rowe, & Tolbert, 1978).

XII. A CONCEPTUAL AND CLINICAL RECAPITULATION

A. Security in interpersonal attachments, the absence of prior stressors, and early opportunities to "tell one's story" in a supportive context, are primary protectors against noxious aftermaths of traumatic events in adults and in children.

B. Posttraumatic stress evoked from an acute traumatic event in children, responds well to small group interventions which allow for affective bonds with which the shared sense of the trauma restores a feeling of community, coupled with the building of bridges toward a better future.

C. Longer-term or very severe traumatization (i.e., familial sexual abuse, witnessing a murder), often require prior, in-depth individual contact, followed by groups level interventions.

D. Trauma-focused helping groups (i.e., crisis intervention and support groups) differ from classical group psychotherapy insofar as, instead of aiming at personality reorganization (repair) they utilize the usually short-term program toward a reconstruction of the traumatic event with its attendant feelings and misconceptions, coupled with plans for future coping and adaptations (i.e. "I may never forget it—but do not need to dwell on it.").

E. Trauma-related groups, generally, share the following elements:

1. Stabilizing the physical and psychological reactions to the trauma;
2. Exploring and validating the members' relevant perceptions and emotions;
3. Retrieving suppressed memories;
4. Understanding the relationship between the stressors and the current behaviors;
5. Eliminating elements of self-blame;
6. Learning new ways of coping;
7. Physical activities, including relaxation exercises and body work.

F. Longer-term support groups are required for children with chronic disabilities, with pathological grieving, as well as with deep-seated posttraumatic stress reactions. Such children may also benefit from heterogeneous psychotherapy groups.

G. Group counselors for the treatment of child-trauma victims, require general personality attributes attuned to working with children, coupled with special training for children's group work with emphasis on group maintenance functions and on therapeutic factors. They also need to be open to an understanding and mastery of inevitable countertransference reactions.

H. Preparatory individual sessions with prospective group members are very desirable and can serve as final means of screening, of obtaining a child's group history, for clarification of misperceptions about the planned group, establish an initial therapeutic alliance and, above all, to work through the usual resistance of traumatized children to the reopening of painful wounds.

XIII. A GLIMPSE AT THE FUTURE

- A. Given the fact that most of the content of this publication was necessarily derived from narrative accounts of clinical experiences and of intuitions of mental health practitioners, the need for evidence-based ways of group intervention with traumatized children, is urgent.
- B. Kazden & Kendall (1998) have outlined the necessary steps toward this goal. Meanwhile, most experts believe that in the absence of additional attacks, most people, and especially children affected by the September 11th disaster, will cope and eventually feel better.
- C. Between 10-25%, mostly children who have been impacted directly or have presented prior risk factors (i.e., earlier traumas; physical or psychological disabilities), are likely to require professional help.
- D. Social supports, including planned small-group interventions are believed to be primary factors in the prevention and treatment of children's trauma.

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