Trauma-Focused CBT Clinical Workbook

State of Delaware
The Department of Services for Children, Youth and Their Families
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SAMHSA

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NCTSN The National Child Traumatic Stress Network

UNIVERSITY OF DELAWARE

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Acknowledgements

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How to Use this Workbook

Therapists who have been trained in TF-CBT will find this workbook to be a useful hands-on companion to the theoretical guide, *Treating Trauma and Traumatic Grief in Children and Adolescents* by Judith A. Cohen, MD, Anthony P Mannarino, Ph.D., and Esther Deblinger, Ph.D., as well as the web-based curriculum TF-CBT*Web* available at www.musc.edu/tfcbt. It has been designed to provide therapists with session activities that closely adhere to the nature and integrity of the treatment model. Competence in the model is a prerequisite for using this book.

The workbook is divided into sections that generally match the ordered steps of this evidence-based treatment. It includes handouts for caregivers and children, exercises that may be used in-session, a comprehensive list of resources, and a special section on therapist self-care for burnout prevention.

Many people have contributed creative ideas to the workbook, based on their own work with the TF-CBT model. Some of the exercises, handouts, and recommended books here are suitable for all ages. Others are meant for a particular age group or population. Please use your judgment in selecting what to use for individual clients, and feel encouraged to tailor exercises to fit your clients' needs. You may find that you are inspired by the creative ideas you find here to come up with exercises and handouts of your own.

We would like to offer our profound appreciation to all of those who have helped bring this workbook to life. We hope you find it useful in your practice of TF-CBT.

Damion J. Grasso, M.A. **Beth Joselow, LPCMH, NCC**

On Behalf of the State of Delaware Division of Prevention and Behavioral Health Services

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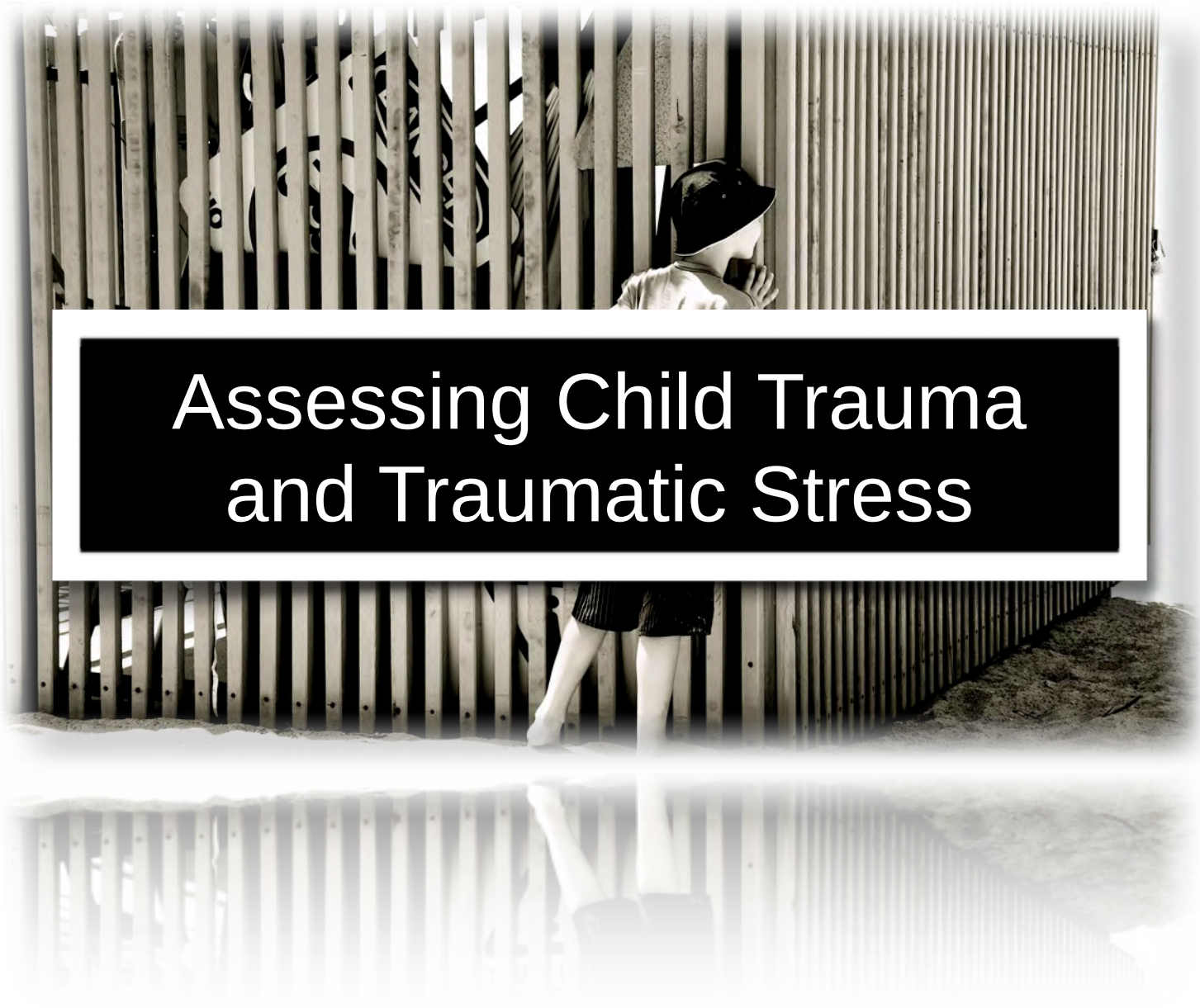

Assessing Child Trauma and Traumatic Stress

Identifying Trauma Exposure and PTSD in Children and Adolescents

WHAT TO EXPECT

About one in four children in the general population will experience a traumatic event before the age of 16 (National Child Traumatic Stress Network, 2008). Community-based studies reveal a lifetime prevalence of Posttraumatic Stress Disorder (PTSD) of approximately 8% in the United States (American Psychiatric Association). However, the prevalence of trauma exposure and PTSD in special populations, such as child welfare, juvenile justice, and hospitalized children is estimated to be much higher. For example, in a number of small-scale research studies in which trauma exposure and PTSD were carefully assessed, about half of children and adolescents involved in child welfare or juvenile justice experienced a traumatic event and about half of these children met full criteria for PTSD. In addition, a large proportion of children who are hospitalized for psychiatric problems have experienced trauma and have symptoms of posttraumatic stress.

As a clinician, you should attempt to determine the rates of trauma exposure in the population that you serve. This information will help you to better assess trauma exposure and PTSD by making you aware of the probable risk of the child having been exposed to trauma and having developed PTSD from it. Sources of prevalence data include epidemiological research reported in published journal articles or on government Internet sites, as well as local data obtained by your institution or agency.

SCREENING

It is recommended that you use a standardized, psychometrically sound assessment instrument to screen for trauma exposure and PTSD symptoms. Instruments that are psychometrically sound have undergone empirical evaluation to determine their accuracy. A psychometrically sound instrument demonstrates good sensitivity and specificity. This means that these instruments are able to predict true cases of PTSD (sensitivity) and cases in which PTSD is not present (specificity).

One psychometrically sound instrument is the UCLA PTSD Reaction Index for the DSM-IV (UCLA PTSD RI; Pynoos et al., 1998). The UCLA PTSD RI is one of the most widely used instruments for assessing trauma in children and adolescents and includes a child and caregiver version. It is conducted using paper and pencil and assesses for trauma exposure and PTSD symptoms from the three symptom clusters: reexperiencing, avoidance, and hyperarousal. The UCLA PTSD RI is designed to assess children ages 7-18 and is comprised of three parts. Part I gathers information on lifetime trauma exposure. Part II examines features of the trauma exposure, and part III examines the frequency/severity of PTSD symptoms.

Please refer to the attached articles on the UCLA PTSD RI for more specific psychometric data and information on administering and scoring the instrument.

The University of California at Los Angeles Post-traumatic Stress Disorder Reaction Index

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Over the past decade, the University of California at Los Angeles Post-traumatic Stress Disorder Reaction Index has been one of the most widely used instruments for the assessment of traumatized children and adolescents. This paper reviews its development and modifications that have been made as the diagnostic criteria for post-traumatic stress disorder have evolved. The paper also provides a description of standard methods of administration, procedures for scoring, and psychometric properties. The Reaction Index has been extensively used across a variety of trauma types, age ranges, settings, and cultures. It has especially been broadly used across the US and around the world after major disasters and catastrophic violence as an integral component of public mental health response and recovery programs. The Reaction Index forms part of a battery that can be efficiently used to conduct needs assessment, surveillance, screening, clinical evaluation, and treatment outcome evaluation after mass casualty events.

Introduction

As diagnostic criteria for post-traumatic stress disorder (PTSD) have evolved over the past two decades, the University of California at Los Angeles (UCLA) PTSD Reaction Index has gone through a number of iterations. In 1985, the UCLA Trauma Psychiatry Program, in collaboration with Calvin Frederick, developed a screening questionnaire based on Diagnostic and Statistical Manual of Mental Disorders (DSM)-III diagnostic criteria for PTSD to assess post-traumatic stress reactions among children and adolescents, the UCLA PTSD Reaction Index [1]. This instrument included 16 items, each rated as no=0, yes=1. Cut-offs for this instrument were established as follows: 0 to 6=none; 7 to 9=mild; 10 to 12=moderate; greater than 12=severe. Although a precursor to this instrument was used among children after the Three Mile Island Nuclear Accident [2], the first major use was to assess post-traumatic stress reactions among elementary school children after a fatal sniper attack on their school playground [3,4]. Subsequently, a DSM-III-R version was developed to take account of modifications to the diagnostic criteria [5,6]. This DSM-III-R version included 20 items, and used a Likert scale to rate the frequency of symptom occurrence over the past month as follows: none of the time=0; a little of the time=1; some of the time=2; much of the time=3; and most of the time=4. During this time period of DSM-III and DSM-III-R, these versions of the UCLA scale were the most widely used clinical and research tools for the assessment of traumatized children, especially in studies of children after disasters.

The UCLA PTSD Reaction Index for DSM-IV (Revision 1) [7] is a revised version of the DSM-III-R scale that is geared closely to DSM-IV criteria for PTSD. The DSM-IV version has child, adolescent, and parent forms, along with accompanying score sheets for each form. Subsequently, the child and adolescent forms were collapsed, using the simpler language of the child form in order to have one instrument for use among children and adolescents. Most recently, an abbreviated version of the symptom scale of this instrument was developed for conducting efficient needs assessment and screening of students in New York City after September 11, 2001. This abbreviated scale, with good sensitivity and specificity for detecting cases of PTSD, was useful in screening populations of children for needs assessment and surveillance in public schools across New York City [8] and in algorithms for clinical assessment and referral for enhanced services within Project Liberty. The full PTSD Reaction Index is currently being used by the Child and

Adolescent Trauma Treatment Service Program administered by the New York State Office of Mental Health to provide services to children and adolescents severely affected by the September 11, 2001 terrorist attacks in New York City.

University of California at Los Angeles Post-traumatic Stress Disorder Reaction Index for *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (Revision 1)

Description

The UCLA PTSD Reaction Index for DSM IV (Revision 1) is a paper and pencil screening instrument for the assessment of trauma exposure and post-traumatic stress symptoms among children and adolescents. Considerable effort was devoted to creating clear and succinct questions that would be easy for respondents to understand. Part I constitutes a brief lifetime trauma screen, allowing for categorization of traumatic exposures, including exposure to community violence, natural disaster, medical trauma, and abuse. These exposure items are scored as present or absent. If more than one event is endorsed, the youth is asked to identify the one currently most bothersome, and a brief summary of the event is recorded. The brief review of the traumatic experience sets the stage for the subsequent questions, helps the child recall details of the traumatic event, and contributes to documenting satisfaction of criterion A1. Part II allows for a systematic evaluation of A1 and A2 DSM-IV criteria that encompass objective and subjective features of the traumatic exposure. These items are also scored as present or absent. Part III provides for a thorough evaluation of the frequency of occurrence of post-traumatic stress symptoms during the past month (rated from 0=none of the time to 4=most of the time). These items map directly onto the DSM-IV criterion B (intrusion), criterion C (avoidance), and criterion D (arousal) for PTSD. Twenty of the items assess PTSD symptoms, whereas two additional items assess associated features—fear of recurrence and trauma-related guilt. These associated features were included in the symptom section because the authors' studies over the past two decades have indicated their public mental health and clinical salience. Fears of recurrence are often pervasive, shared across dimensions of exposure, and represent children's perception of the seriousness of the danger. Trauma-related guilt for perceived commission or omission of actions has been found to increase overall severity of post-traumatic stress reactions within categories of exposure, and can serve as an important indicator for triage. The instrument is accompanied by a frequency rating sheet to visually assist children in providing accurate responses about how often the reaction has occurred over the past month. There is also a score sheet with instructions for tabulation of total score, and B, C and D symptom subscale scores. Although the instrument was not designed to be diagnostic, it can provide preliminary diagnostic information.

The continuous scale, however, allows for finer discrimination across exposure groups, and is especially useful in informing clinical treatment and public mental health planning. Continuous scale instruments have important use in treatment outcome studies and public health monitoring of course of recovery after catastrophic events.

Administration and scoring

The UCLA Reaction Index for DSM-IV (Revision 1) can be administered, scored, and interpreted by a graduate level student under the supervision of a licensed Master's level clinician with experience in the area of assessment of trauma exposure and PTSD in children. The measure may be administered in the following three ways: 1) as a self-administered paper and pencil measure; 2) by one-to-one verbal administration, in which the instructions and questions are read to the child; and 3) by group administration, for example, in a classroom setting in which the instrument can be self-administered or read aloud to the group. To increase reliability, it is helpful to repeat the time frame being asked about (over the past month) for each item, and to insert reference to the specific traumatic event within items that ask about symptoms in regard to "what happened" or "the bad thing that happened." The instrument was designed for use with youth from 7 to 18 years of age. It is recommended that the instructions and questions be read aloud to children under the age of 12 or to youth with known reading comprehension difficulties. Time for completion of the instrument varies with age, reading ability of the child, and method of administration, but typically can be completed in 20 to 30 minutes.

The score sheet provides for coding endorsement of exposure to a traumatic event in Part I, and criteria A1 and A2 in Part II. Although the symptom scale contains 20 PTSD symptom–related items, only 17 scores (corresponding to the 17 DSM-IV PTSD symptom criteria) make up the total symptom scale score in Part III. Three of the symptom criteria have two alternative formulations, with the highest frequency score used to calculate the total score. The score sheet provides instructions for calculating a total PTSD severity score, and severity scores for each of the DSM-IV B, C, and D subcategories. When criterion A is met, children who meet criteria B, C, and D (using endorsements of "much of the time" and "most of the time" as indicating symptom presence) are scored as having a likely diagnosis of DSM-IV "full" PTSD. Where criterion A is met, children meeting criteria for only two symptom subcategories are scored as "partial" PTSD likely. A cut-off of 38 or greater for a single incident traumatic event

has the greatest sensitivity and specificity for detecting PTSD [9,10]. Scoring of the instrument takes approximately 5 to 10 minutes.

Populations studied

Over the past two decades, versions of the UCLA PTSD Reaction Index have been translated and broadly used in clinical evaluation, trauma research, and post-disaster screening and recovery programs across the US and around the world. As a result, the Reaction Index has been widely translated for use across various settings and cultures. For example, with regard to natural disasters, the Reaction Index was used for over a decade in the largest post-disaster public mental health recovery program that followed the 1988 Spitak earthquake in Armenia [6,11–15]. In this work, its use has been demonstrated for needs assessment, surveillance, and clinical studies and also in the study of neurohormonal and developmental alterations [13,15]. The Reaction Index was used after the 1994 Northridge Earthquake in California [16], and has been recently translated into Turkish for use after the 1999 Marmara earthquake in Turkey [17], and into Cantonese and Greek for use after the 1999 earthquakes in Taiwan [18], and Greece [19•]. It has also been used after the two most studied hurricanes, Hurricane Hugo [20,21] and Hurricane Andrew [22–25]. It was also used more recently in Nicaragua after Hurricane Mitch [26•]. Modified versions were used in Hawaii after Hurricane Iniki [27] and after an industrial fire [28].

The Reaction Index has been used among children and adolescents after large-scale political violence, for example, in Bosnia and Herzegovina [29,30], Mozambique [31], Kuwait [32], Israel [33–35], Palestine [36,37], and Lebanon [38]. In the US, it has been used among Cambodian adolescents exposed to atrocities [39], children exposed to the bombing of the Federal Building in Oklahoma City [40], and after the 2001 terrorist attack on the World Trade Center in New York City [41,42].

It has also been used in research and treatment outcome studies among children exposed to community violence [43,44], catastrophic school violence after a sniper attack [3], a school shooting [45], among children who witnessed the sexual assault of their mother [5], and adolescents who witnessed the suicide of a peer [46]. Additionally, it has been used among children after severe dog bites [47], children with life-threatening medical illness [48–55], children with severe burn injuries [53], and among children and adolescents after traffic accidents [54,55].

Psychometric properties

Over the years, successive versions of the UCLA PTSD Reaction Index have been psychometrically studied. Validity across all the versions is suggested by numerous studies that have found consistently higher Reaction Index scores among traumatized samples compared with control subjects, and a clear "dose of exposure" relationship of Reaction Index scores across exposure groups. Convergent validity has been supported by the agreement of cut-off scores with a diagnosis of PTSD. For example, in studies after the 1988 earthquake in Armenia, Pynoos *et al.* [6] reported a significant association between the severity categories of the DSM-III-R version and a DSM-III-R diagnosis of PTSD, with a cut-off of 40 or higher correctly identifying 78% of subjects who met DSM-III-R criteria, and 79% of those who did not. Of those subjects who scored 40 or higher, 90% met the DSM-III-R criteria for PTSD. The DSM-IV version has good convergent validity, 0.70 in comparison with the PTSD Module of the Schedule for Affective Disorders and Schizophrenia for School-Age Children, Epidemiologic version (0.82 in comparison with the Child and Adolescent Version of the Clinician-administered PTSD Scale), with a cut-off of 38 having a sensitivity of 0.93 and specificity of 0.87 in detecting PTSD [9,10].

With regard to internal consistency across versions, several reports have found Chronbach's alpha to fall in the range of 0.90 [9,10,19•,29]. Again, over the different versions, test-retest reliability has ranged from good to excellent, with Pynoos *et al.* [3] reporting a test-retest inter-item agreement of 94% for the DSM-III version. Subsequently, Goenjian *et al.* [26•] reported an intra-class correlation coefficient of 0.93 for adolescents evaluated with the DSM-II-R version initially and again after 7 days, whereas Roussos *et al.* [19•] recently reported a test-retest reliability coefficient of 0.84 for the DSM-IV version. With regard to the seven- and nine-item abbreviated UCLA PTSD Reaction Index scales, the Cronbach's alpha was 0.85 for the seven-item scale, and 0.87 for the nine-item scale. The receiver operator characteristic curves indicated that corresponding cut-offs to the full scale are 16 for the seven-item scale and 20 for the nine-item scale.

Conclusions

Part II items of the DSM-IV version of the UCLA PTSD Reaction Index (those assessing objective and subjective features of exposure) are currently rated using a "yes/no" format. As suggested by Goenjian *et al.* [26•], having these items rated on a Likert scale would render them more sensitive to detecting differences across exposure groups. There is also a need to add items that assess related functional impairment as reflected in DSM-IV criterion F (interference with important areas of functioning, including peer, school, and family).

Over the years, the UCLA PTSD Reaction Index has proven to be an extremely useful part of an assessment battery (along with specific exposure questions, questions about post-event stresses and adversities, and measures of comorbid depression, grief, and anxiety) that has been used effectively to conduct needs assessment, surveillance, screening, clinical evaluation, and treatment

outcome evaluation after traumatic events. Most recently, several new scales have been developed, including the UCLA Trauma Reminder Inventory [56] and the UCLA/Brigham Young Expanded Grief Inventory [57]. The National Center for Child Traumatic Stress Traumatic Loss Reminder Inventory [58] provides a clinically useful tool to identify the types and frequency of exposure to loss reminders, the frequency and intensity of reactivity to them, and the extent to which exposure to such reminders interferes with academic, peer, and family functioning. The Measures and Data Operations Committees of the National Child Traumatic Stress Network have selected the UCLA PTSD Reaction Index for DSM-IV to be a core data instrument for Network-wide use. In doing so, they will be developing Internet-based tools that allow for data entry and software that can provide information for clinicians about symptom profile and algorithms for strategies of intervention and monitoring course of recovery. Past work examining the pattern of accrual of symptoms across dose of exposure [3] suggests that the Reaction Index will be useful for developing algorithms to guide intervention decision-making. Symptom cluster analyses have also indicated its use in identifying risks of associated functional impairment [59] that may also guide algorithms for intervention.

References and Recommended Reading

Papers of particular interest, published recently, have been highlighted as:

- • Of importance
- •• Of major importance

1. Frederick CJ: **Selected foci in the spectrum of posttraumatic stress disorders.** In *Perspectives on Disaster Recovery.* Edited by Laube J, Murphy SA, East Norwalk: Appleton-Centrury-Crofts; 1985:110–130.
2. Tokuhata G, Bratz J, Kim J: *Three Mile Island: Mother-Child Morbidity Survey.* Harrisburg: PA Department of Health; 1984.
3. Pynoos RS, Frederick C, Nader K, *et al.*: **Life threat and posttraumatic stress in school-age children.** *Arch Gen Psychiatry* 1987, **44:**1057–1063.
4. Nader K, Pynoos RS, Fairbanks LA, Frederick C: **Children's PTSD reactions one year after a sniper attack at their school.** *Am J Psychiatry* 1990, **147:**1526–1530.
5. Pynoos RS, Nader K: **Children who witness the sexual assaults of their mothers.** *J Am Acad Child Adolesc Psychiatry* 1988, **27:**567–572.
6. Pynoos R, Goenjian A, Tashjian M., *et al.*: **Posttraumatic stress reactions in children after the 1988 Armenian earthquake.** *Br J Psychiatry* 1993, **163:**239–224.
7. Pynoos RS, Rodriguez N, Steinberg AS, *et al.*: *The UCLA PTSD Reaction Index for DSM IV (Revision 1).* Los Angeles: UCLA Trauma Psychiatry Program; 1998.
8. **New York City Board of Education: Effects of the World Trade Center Attack on NYC Public School Students: Initial Report. New York: Applied Research and Consulting, LLC, Columbia University Mailman School of Public Health, New York State Psychiatric Institute;** 2002.
9. Rodriguez N, Steinberg AS, Saltzman WS, Pynoos RS: **PTSD Index: psychometric analyses of the adolescent version.** *Symposium conducted at the Annual Meeting of the International Society for Traumatic Stress Studies.* New Orleans, LA; December 6–9, 2001.
10. Rodriguez N, Steinberg AS, Saltzman WS, Pynoos RS: **PTSD Index: preliminary psychometric analyses of child and parent versions.** *Symposium conducted at the Annual Meeting of the International Society for Traumatic Stress Studies.* New Orleans, LA; December 6-9, 2001.
11. Goenjian AK, Pynoos RS, Steinberg AM, *et al.*: **Psychiatric comorbidity in children after the 1988 earthquake in Armenia.** *J Am Acad Child Adolesc Psychiatry* 1995, **34:**1174–1184.
12. Goenjian AK, Pynoos RS, Karayan I, *et al.*: **Outcome of psychotherapy among pre-adolescents after the 1988 earthquake in Armenia.** *Am J Psychiatry* 1997, **154:**536–542.
13. Goenjian AK, Stilwell BM, Steinberg AM, *et al.*: **Moral development and psychopathological interference with conscience functioning among adolescents after trauma.** *J Am Acad Child Adolesc Psychiatry* 1999, **38:**376–384.
14. Goenjian AK, Najarian LM, Steinberg AM, *et al.*: **A prospective study of posttraumatic stress, anxiety and depressive reactions after earthquake and violence.** *Am J Psychiatry* 2000, **157:**911–916.
15. Goenjian AK, Pynoos RS, Steinberg AM, *et al.*: **Hypothalamic-pituitary-adrenal activity among Armenian adolescents with PTSD symptoms.** *J Trauma Stress* 2003, **16:**319–232.
16. Asarnow J, Glynn S, Pynoos RS: **When the earth stops shaking: earthquake sequelae among children diagnosed for pre-earthquake psychopathology.** *J Am Acad Child Adolesc Psychiatry* 1999, **38:**1016–1023.
17. Laor N, Wolmer L, Kora M, *et al.*: **Posttraumatic, dissociative and grief symptoms in Turkish children exposed to the 1999 earthquakes.** *J Nerve Ment Dis* 2002, **190:**824–832.
18. Chen SH, Lin YH, Tseng HM, Wu YC: **Posttraumatic stress reactions in children and adolescents one year after the 1999 Taiwan Chi-Chi earthquake.** *J Chin Inst Eng* 2002, **25:**597–609.
19. • Roussos A, Goenjian AK, Steinberg AM, *et al.*: **Posttraumatic stress and depressive reactions after the 1999 Ano Liosia earthquake in Greece.** *Am J Psychiatry* 2004, in press.

This study, which used the UCLA PTSD Reaction Index for DSM-IV (Revision 1), describes the psychometric properties and the use of this instrument after a moderate earthquake. The findings indicated that the PTSD score was the single most powerful variable predicting depression.

20. Shannon MP, Lonigan CJ, Finch AJ, Taylor CM: **Children exposed to disaster, I: epidemiology of posttraumatic symptoms and symptom profiles.** *J Am Acad Child Adolesc Psychiatry* 1994, **33:**80–93.
21. Garrison CZ, Weinrich MW, Hardin SB, *et al.*: **Posttraumatic stress disorder in adolescents after a hurricane.** *Am J Epidemiol* 1993, **138:**522–530.
22. Vernberg EM, La Greca AM, Silverman WK, Prinstein MJ: **Predictions of post-traumatic stress symptoms in children after Hurricane Andrew: a prospective study.** *J Consult Clin Psychol* 1996, **64:**712–723.
23. Garrison CZ, Bryant BS, Eddy CL, *et al.*: **Posttraumatic stress disorder in adolescents after a Hurricane Andrew.** *J Am Acad Child Adolesc Psychiatry* 1995, **34:**1193–1201.
24. Shaw JA, Applegate B, Tanner S, *et al.*: **Psychological effects of Hurricane Andrew on an elementary school population.** *J Am Acad Child Adolesc Psychiatry* 1995, **34:**1185–1192.
25. La Greca AM, Silverman WK, Vernberg EM, Prinstein MJ: **Symptoms of posttraumatic stress in children after Hurricane Andrew: a prospective study.** *J Consult Clin Psychol* 1996, **64:**712–723.
26. • Goenjian AK, Molina L, Steinberg AM, *et al.*: **Posttraumatic stress and depressive reactions among adolescents in Nicaragua after Hurricane Mitch.** *Am J Psychiatry* 2001, **158:**788–794.

This paper found that severe exposure after a Category 5 hurricane led to severe post-traumatic stress and comorbid depressive reactions. These results emphasize the importance of establishing a comprehensive post-disaster recovery program that includes systematic screening.

27. Chemtob CM, Nakashima JP, Hamada RS: **Psychosocial intervention for post-disaster trauma symptoms in elementary school children: a controlled community field study.** *Arch Pediatr Adolesc Med* 2002, **156:**211–216.
28. March JS, Amaya-Jackson L, Terry R, Costanzo P: **Posttraumatic symptomatology in children and adolescents after an industrial fire.** *J Am Acad Child Adolesc Psychiatry* 1997, **36:**1080–1088.
29. Layne CM, Saltzman WR, Arslanagic B, *et al.*: **Trauma/grief focused group psychotherapy: school-based postwar intervention with traumatized Bosnian adolescents.** *Group Dynamics: Theory, Research and Practice* 2001, **5:**277–290.
30. Allwood MA, Bell-Dolan D, Husain FA: **Children's trauma and adjustment reactions to violent and non-violent war experiences.** *J Am Acad Child Adolesc Psychiatry* 2002, **41:**450–457.
31. Shaw JA, Harris JJ: **Children of war and children at war: child victims of terrorism in Mozambique.** In *Terrorism and Disaster: Individual and Community Mental Health Interventions*. Edited by Ursano RJ. New York: Cambridge University Press; 2003:41–57.
32. Nader K, Pynoos RS, Fairbanks LA, *et al.*: **Acute post-traumatic reactions among Kuwait children following the Gulf crisis.** *Br J Clin Psychol* 1993, **32:**407–416.
33. Schwarzwald J, Weisenberg M, Waysman M, *et al.*: **Stress reactions to school-age children to the bombardment by SCUD missiles.** *J Abnorm Psychol* 1993, **102:**404–410.
34. Laor N, Wolmer L, Mayes LC, *et al.*: **Israeli preschool children under Scuds: a 30-month follow-up.** *J Am Acad Child Adolesc Psychiatry* 1997, **36:**349–356.
35. Laor N, Wolmer L, Cohen DJ: **Mothers' functioning and children's symptoms 5 years after a SCUD missile attack.** *Am J Psychiatry* 2001, **158:**1020–1026.
36. Thabet AA, Vostanis P: **Posttraumatic stress reactions in children of war.** *J Child Psychol Psychiatry* 1999, **40:**385–391.
37. Thabet AA, Vostanis P: **Posttraumatic stress reactions in children of war: a longitudinal study.** *Child Abuse Neglect* 2000, **24:**291–298.
38. Macksoud MS, Aber JL: **The war experiences and psychosocial development of children in Lebanon.** *Child Dev* 1996, **67:**70–88.
39. Realmuto GM, Masten A, Carole LF, *et al.*: **Adolescent survivors of massive childhood trauma in Cambodia: life events and current symptoms.** *J Trauma Stress* 1992, **5:**589–599.
40. Pfefferbaum B, Nixon SJ, Tucker PM, *et al.*: **Posttraumatic stress responses in bereaved children after the Oklahoma City bombing.** *J Am Acad Child Adolesc Psychiatry* 1995, **38:**1372–1379.
41. Koplewicz HS, Vogel JM, Solanto MV, *et al.*: **Child and parent response to the 1993 World Trade Center bombing.** *J Trauma Stress* 2002, **15:**77–85.
42. Fairbrother G, Stuber J, Galea S, *et al.*: **Posttraumatic stress reactions in New York City children after the September 11th terrorist attacks.** *Ambul Pediatr* 2003, **3:**304–311.
43. Saltzman WR, Pynoos RS, Layne CM, *et al.*: **Trauma- and grief-focused intervention for adolescents exposed to community violence: results of a school-based screening and group treatment protocol.** *Group Dynamics: Theory, Research and Practice* 2001, **5:**291–303.
44. Berman SL, Kurtines WM, Silverman WK, Serafini LT: **The impact of exposure to crime and violence on urban youth.** *Am J Orthopsychiatry* 1996, **66:**329–336.
45. Brymer MJ, Steinberg AM, McGlenn R, Pynoos RS: **Santana high school shooting: a public mental health response.** *Presented at the 18th Annual Meeting of the International Society for Traumatic Stress Studies*. Baltimore, MD; November 7–10, 2002.
46. Brent DA, Perper JA, Moritz G, *et al.*: **Adolescent witnesses to a peer suicide.** *J Am Acad Child Adolesc Psychiatry* 1993, **32:**1184–1188.
47. Rossman BBR, Bingham RD, Emde RN: **Symptomatology and adaptive functioning for children exposed to normative stressors, dog attack, and parental violence.** *J Am Acad Child Adolesc Psychiatry* 1997, **36:**1089–1097.
48. Stuber ML, Nader K, Yasuda P, *et al.*: **Stress responses after pediatric bone marrow transplantation: preliminary results of a prospective longitudinal study.** *J Am Acad Child Adolesc Psychiatry* 1991, **30:**952–957.
49. Stuber M, Nader K: **Psychiatric sequelae in adolescent bone marrow transplantation survivors: implications for psychotherapy.** *J Psychother Pract Res* 1995, **4:**30–42.
50. Stuber M, Christakis Houskamp B, Kazak AE: **Posttraumatic symptoms in childhood leukemia survivors and their parents.** *Psychosomatics* 1996, **37:**254–261.
51. Kazak AE, Barakat LP, Meeske K, *et al.*: **Posttraumatic stress symptoms, family functioning, and social support in survivors of childhood leukemia and their mothers and fathers.** *J Consult Clin Psychol* 1997, **65:**120–129.
52. Stuber ML, Kazak AE, Meeske K, *et al.*: **Predictors of posttraumatic stress symptoms in childhood cancer survivors.** *Pediatrics* 1997, **6:**958–964.
53. Saxe G, Stoddard F, Courtney D, *et al.*: **Relationship between acute morphine and the course of PTSD in children with burns.** *J Am Acad Child Adolesc Psychiatry* 2001, **40:**915–921.
54. Mirza KAH, Bhadrinath BR, Goodyer IM, Gilmour C: **Posttraumatic stress disorder in children and adolescents following road traffic accidents.** *Br J Psychiatry* 1998, **172:**443–447.
55. Zatzick DF, Grossman D, Jurkovich J, Rivara FP: **The design of the Adolescent Trauma Recovery and Stress Disorders Cohort (ATRSC) Study.** *Paper presented at Harborview Injury Prevention and Research Center*. Seattle, WA; 2002.
56. Steinberg AM, Rodriguez N, Goenjian AK, Pynoos RS: *UCLA Trauma Reminder Inventory.* Los Angeles: UCLA Trauma Psychiatry Program; 2002.
57. Layne CM, Savjak N, Saltzman WR, Pynoos RS: *The UCLA/BYU Expanded Grief Inventory.* Los Angeles:UCLA Trauma Psychiatry Program; 2001.
58. Steinberg AM, Rodriguez N, Goenjian AK, *et al.*: *National Center for Child Traumatic Stress Traumatic Loss Reminder Inventory.* Los Angeles: National Center for Child Traumatic Stress; 2001.
59. Carrion VG, Weems CF, Ray R, Reiss AI: **Toward and empirical definition of pediatric PTSD: the phenomenology of PTSD symptoms in youth.** *J Am Acad Child Adolesc Psychiatry* 2002, **41:**166–173.

UCLA PTSD INDEX FOR DSM IV ©

Name _____ Age _____ Sex (Circle): Girl Boy
Today's Date (**write month, day and year**) _____ Grade in School _____
School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences, some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

FOR EACH QUESTION:	**Check "Yes"** if this scary thing **HAPPENED TO YOU** **Check "No"** if it **DID *NOT* HAPPEN TO YOU**

1)	Being in a big earthquake that badly damaged the building you were in.	Yes [ ]	No [ ]
2)	Being in another kind of **disaster**, like a fire, tornado, flood or hurricane.	Yes [ ]	No [ ]
3)	Being in a bad **accident**, like a **very serious** car accident.	Yes [ ]	No [ ]
4)	Being in place where a **war** was going on around you.	Yes [ ]	No [ ]
5)	Being **hit, punched, or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ]	No [ ]
6)	Seeing a family member being **hit, punched or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ]	No [ ]
7)	Being **beaten up, shot at or threatened to be hurt badly** in your town.	Yes [ ]	No [ ]
8)	Seeing someone in your town being **beaten up, shot at or killed.**	Yes [ ]	No [ ]
9)	Seeing a **dead body** in your town (do not include funerals).	Yes [ ]	No [ ]
10)	Having an adult or someone much older touch your **private sexual body parts** when you did not want them to.	Yes [ ]	No [ ]
11)	Hearing about the **violent death or serious injury** of a loved one.	Yes [ ]	No [ ]
12)	Having **painful and scary medical treatment in a hospital** when you were very sick or badly injured.	Yes [ ]	No [ ]

Contact: UCLA Trauma Psychiatry Service
300 UCLA Medical Plaza, Ste 2232
Los Angeles, CA 90095-6968 (310) 206-8973
EMAIL: rpynoos@mednet.ucla.edu

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to you that was **REALLY SCARY, DANGEROUS OR VIOLENT?** Yes [ ] No [ ]

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank. # _____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOU THE MOST NOW** in this blank. #_____

c) About how long ago did this bad thing (your answer to [a] or [b]) happen to you? _____

d) Please write what happened: _____

_____

_____

_____

_____

FOR THE *NEXT* QUESTIONS, please **CHECK [YES] or [NO]** to answer **HOW YOU FELT during or right after** the bad thing happened that you just wrote about in Question 14.

15) Were you scared that you would die?	Yes [ ]	No [ ]
16) Were you scared that you would be hurt badly?	Yes [ ]	No [ ]
17) Were you hurt badly?	Yes [ ]	No [ ]
18) Were you scared that someone else would die?	Yes [ ]	No [ ]
19) Were you scared that someone else would be hurt badly?	Yes [ ]	No [ ]
20) Was someone else hurt badly?	Yes [ ]	No [ ]
21) Did someone die?	Yes [ ]	No [ ]

22) Did you feel very scared, like this was one of your most scary experiences ever?	Yes [ ]	No [ ]
23) Did you feel that you could not stop what was happening or that you needed someone to help?	Yes [ ]	No [ ]
24) Did you feel that what you saw was disgusting or gross?	Yes [ ]	No [ ]
25) Did you run around or act like you were very upset?	Yes [ ]	No [ ]
26) Did you feel very confused?	Yes [ ]	No [ ]
27) Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes [ ]	No [ ]

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened to you that you wrote about in Question #14 on the page 2. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 5 to help you decide how often the problem has happened in the past month.

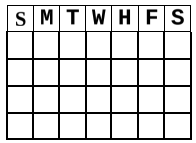
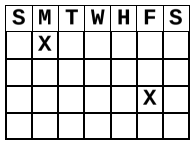
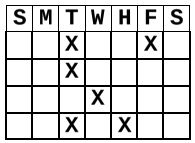
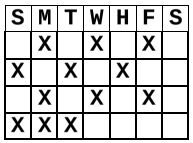
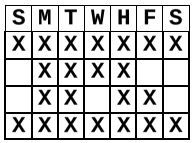
PLEASE BE SURE TO ANSWER ALL QUESTIONS

HOW MUCH OF THE TIME DURING THE PAST MONTH	**None**	**Little**	**Some**	**Much**	**Most**
1_{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2_{B4} When something reminds me of what happened, I get very upset, afraid or sad.	0	1	2	3	4
3_{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4_{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5_{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6_{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7_{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4

HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
8_{C5} I feel alone inside and not close to other people.	0	1	2	3	4
9_{C1} I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10_{C6} I have trouble feeling happiness or love.	0	1	2	3	4
11_{C6} I have trouble feeling sadness or anger.	0	1	2	3	4
12_{D5} I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13_{D1} I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14_{AF} I think that some part of what happened is my fault.	0	1	2	3	4
15_{C3} I have trouble remembering important parts of what happened.	0	1	2	3	4
16_{D3} I have trouble concentrating or paying attention.	0	1	2	3	4
17_{C2} I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18_{B5} When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	0	1	2	3	4
19_{C7} I think that I will not live a long life.	0	1	2	3	4
20_{D2} I have arguments or physical fights.	0	1	2	3	4
21_{C7} I feel pessimistic or negative about my future.	0	1	2	3	4
22_{AF} I am afraid that the bad thing will happen again.	0	1	2	3	4

FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME
DURING THE PAST MONTH, THAT IS SINCE _____,
DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	**LITTLE**	**SOME**	**MUCH**	**MOST**
				
NEVER	**TWO TIMES A MONTH**	**1-2 TIMES A WEEK**	**2-3 TIMES EACH WEEK**	**ALMOST EVERY DAY**

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: ADOLESCENT VERSION©

Subject ID#_____ Age_____ Sex (circle): M F # of days since traumatic event _____

CRITERION A-TRAUMATIC EVENT

Exposure to Traumatic Event
Questions 1-13: at least 1 "Yes" answer **YES** **NO**

Type of Traumatic Event rated as most distressing (Question 14: write trauma type in the blank) _____

Criterion A1 met
Questions 15-21: at least 1 "Yes" answer **YES** **NO**

Criterion A2 met
Questions 22-26: at least 1 "Yes" answer **YES** **NO**

Criterion A met **YES** **NO**

Peritraumatic Dissociation **YES** **NO**
Question 27: answer "Yes"

PTSD SEVERITY: OVERALL SCORE

Question # /Score	Question # /Score
1. _____	12._____
2. _____	13._____
3. _____	[Omit 14].
+4. *or*	15._____
20. _____	16._____
5. _____	17._____
6. _____	18._____
7. _____	=19. or
8. _____	21._____
9. _____	[Omit 22].
* 10. *or*	**(Sum total** **PTSD SEVERITY**
11._____	**of scores) =** _____ **SCORE**

+Place the highest Score from either Question 4 *or* 20 in the blank above: Score Question 4._____/Score Question 20._____
*Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10._____/Score Question 11._____
= Place the highest Score from either Question 19 *or* 21 in the blank above: Score Question 19._____/Score Question 21._____

CRITERION B (REEXPERIENCING) SX.

Question #/DSM-IV Symptom	Score	
3. (B1) Intrusive recollections	_____	
5. (B2) Trauma/bad dreams	_____	
6. (B3) Flashbacks	_____	# of Criterion B
2. (B4) Cues: Psychological reactivity	_____	Questions with Score ≥ Symptom
18. (B5) Cues: Physiological reactivity	_____	Cutoff: _____

CRITERION B SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION B MET:
(Diagnosis requires at least 1 "B" Symptom): **YES** **NO**

CRITERION C (AVOIDANCE) SX.

Question #/DSM-IV Symptom	Score	
9. (C1) Avoiding thoughts/feelings	_____	
17. (C2) Avoiding activities/people	_____	
15. (C3) Forgetting	_____	# of Criterion C
7. (C4) Diminished interest etc.	_____	Questions with
8. (C5) Detachment/estrangement	_____	Scores ≥ Symptom
*10. *or* 11. (C6) Affect restricted	_____	Cutoff: _____
=19. *or* 21. (C7) Foreshort. future	_____	

[*Place the highest Score from either Question 10 *or* 11 in the blank above; = Place the highest Score from either Question 19 *or* 21 in the blank above.]

CRITERION C SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION C MET:
(Diagnosis requires at least 3 "C" Symptoms): **YES** **NO**

CRITERION D (INCREASED AROUSAL) SX.

Question #/DSM-IV Symptom	Score	
13. (D1) Sleep problems	_____	
+4. *or* 20. (D2) Irritability/anger	_____	
16. (D3) Concentration problems	_____	# of Criterion D
1. (D4) Hypervigilance	_____	Questions with
12. (D5) Exaggerated startle	_____	Score ≥ Symptom Cutoff: _____

[+Place the highest Score from either Question 4 *or* 20 in the blank above.]
CRITERION D SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION D MET:
(Diagnosis requires at least 2 "D" Symptoms): **YES** **NO**

DSM-IV PTSD DIAGNOSTIC INFO.

DSM-IV FULL PTSD DIAGNOSIS LIKELY
(Criteria A, B, C, D all met) **YES** **NO**

PARTIAL PTSD LIKELY
(Criterion A met and:
Criteria B + C or B + D or C + D) **YES** **NO**

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: CHILD VERSION©

Subject ID#_____ Age_____ Sex (circle): M F # of days since traumatic event _____

CRITERION A-TRAUMATIC EVENT

Exposure to Traumatic Event
Questions 1-13: at least 1 "Yes" answer **YES** **NO**

Type of Traumatic Event rated as most distressing (Question 14: write trauma type in the blank) _____

Criterion A1 met
Questions 15-21: at least 1 "Yes" answer **YES** **NO**

Criterion A2 met
Questions 22-26: at least 1 "Yes" answer **YES** **NO**

Criterion A met **YES** **NO**

Peritraumatic Dissociation **YES** **NO**
Question 27: answer "Yes"

PTSD SEVERITY: OVERALL SCORE

Question # /Score	Question # /Score
1._____	12._____
2._____	13._____
3._____	[Omit 14].
4. _____	15._____
5._____	16._____
6._____	17._____
7. _____	18._____
8. _____	19._____
9. _____	[Omit 20].
* 10. *or*	
11._____	

(Sum the items from the above 2 columns, write sum below)

(Sum total of scores) = _____ **PTSD SEVERITY SCORE**

*Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____

CRITERION B (REEXPERIENCING) SX.

Question #/DSM-IV Symptom	Score	
3. (B1) Intrusive recollections	_____	
5. (B2) Trauma/bad dreams	_____	
6. (B3) Flashbacks	_____	# of Criterion B
2. (B4) Cues: Psychological reactivity	_____	Questions with Score ≥ Symptom
18. (B5) Cues: Physiological reactivity	_____	Cutoff: _____

CRITERION B SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION B MET:
(Diagnosis requires at least 1 "B" Symptom): **YES** **NO**

CRITERION C (AVOIDANCE) SX.

Question #/DSM-IV Symptom	Score	
9. (C1) Avoiding thoughts/feelings	_____	
17. (C2) Avoiding activities/people	_____	
15. (C3) Forgetting	_____	# of Criterion C
7. (C4) Diminished interest etc.	_____	Questions with
8. (C5) Detachment/estrangement	_____	Scores ≥ Symptom
*10. *or* 11. (C6) Affect restricted	_____	Cutoff: _____
19. (C7) Foreshort. future	_____	

[*Place the highest Score from either Question 10 *or* 11 in the blank above.]

CRITERION C SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION C MET:
(Diagnosis requires at least 3 "C" Symptoms): **YES** **NO**

CRITERION D (INCREASED AROUSAL) SX.

Question #/DSM-IV Symptom	Score	
13. (D1) Sleep problems	_____	
4. (D2) Irritability/anger	_____	
16. (D3) Concentration problems	_____	# of Criterion D
1. (D4) Hypervigilance	_____	Questions with
12. (D5) Exaggerated startle	_____	Score ≥ Symptom Cutoff: _____

[+Place the highest Score from either Question 4 *or* 20 in the blank above.]

CRITERION D SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION D MET:
(Diagnosis requires at least 2 "D" Symptoms): **YES** **NO**

DSM-IV PTSD DIAGNOSTIC INFO.

DSM-IV FULL PTSD DIAGNOSIS LIKELY
(Criteria A, B, C, D all met) **YES** **NO**

PARTIAL PTSD LIKELY
[Criterion A met and:
Criteria (B + C) or (B + D) or (C + D)] **YES** **NO**

UCLA PTSD INDEX FOR DSM-IV (Parent Version, Revision 1) © Page 1 of 5

Child's Name _____ Age _____ Sex (Circle): Girl Boy
Name of Person Completing this Form _____ Relationship to Child _____
Today's Date (**write month, day and year**) _____ Grade in School _____
School _____ Teacher _____ Town _____
Below is a list of VERY SCARY, DANGEROUS OR VIOLENT things that sometimes happen to children. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some children have had these experiences, some children have not had these experiences. Please be honest in answering if the violent thing happened to your child , or if it did not happen to your child.

FOR EACH QUESTION: Check "Yes" if this scary thing **HAPPENED TO YOUR CHILD**
Check "No" if it **DID *NOT* HAPPEN TO YOUR CHILD**

1) Being in a big earthquake that badly damaged the building your child was in. Yes [ ] No [ ]

2) Being in another kind of **disaster**, like a fire, tornado, flood or hurricane. Yes [ ] No [ ]

3) Being in a bad **accident**, like a **very serious** car accident. Yes [ ] No [ ]

4) Being in place where a **war** was going on around your child. Yes [ ] No [ ]

5) Being **hit, punched, or kicked very hard** at home.
(**DO NOT INCLUDE** ordinary fights between brothers & sisters). Yes [ ] No [ ]

6) Seeing a family member being **hit, punched or kicked very hard** at home.
(**DO NOT INCLUDE** ordinary fights between brothers & sisters). Yes [ ] No [ ]

7) Being **beaten up, shot at or threatened to be hurt badly** in your town. Yes [ ] No [ ]

8) Seeing someone in your town being **beaten up, shot at or killed.** Yes [ ] No [ ]

9) Seeing a **dead body** in your town (do not include funerals). Yes [ ] No [ ]

10) Having an adult or someone much older touch your child's
private sexual body parts when your child did not want them to. Yes [ ] No [ ]

11) Hearing about the **violent death or serious injury** of a loved one. Yes [ ] No [ ]

12) Having **painful and scary medical treatment in a hospital** when your child
was very sick or badly injured. Yes [ ] No [ ]

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened
to your child that was **REALLY SCARY, DANGEROUS OR VIOLENT?** Yes [ ] No [ ]
Please write what happened: _____

Contact: UCLA Trauma Psychiatry Service/ 300 UCLA Medical Plaza, Ste 2232
Los Angeles, CA 90095 -6968
(310) 206-8973/ EMAIL: rpynoos@mednet.ucla.edu

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank. # _____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOUR CHILD THE MOST NOW** in this blank. #_____

c) About how long ago did this bad thing (your answer to Aa≅ or Ab≅) happen to your child? _____

d) Please write what happened: _____

_____

_____

_____

FOR THE *NEXT* QUESTIONS, please **CHECK "Yes, No, or Don't know"** to answer **HOW YOUR CHILD FELT during or right after** the experience happened that you just wrote about in Question 14. Only check "Don't Know" if you absolutely cannot give an answer.

15) Was your child afraid that he/she would die?	Yes [ ]	No [ ]	Don't know [ ]
16) Was your child afraid that he/she would be seriously injured?	Yes [ ]	No [ ]	Don't know [ ]
17) Was your child seriously injured?	Yes [ ]	No [ ]	
18) Was your child afraid that someone else would die?	Yes [ ]	No [ ]	Don't know [ ]
19) Was your child afraid that someone else would be seriously injured?	Yes [ ]	No [ ]	Don't know [ ]
20) Was someone else seriously injured?	Yes [ ]	No [ ]	
21) Did someone die?	Yes [ ]	No [ ]	
22) Did your child feel terrified?	Yes [ ]	No [ ]	Don't know [ ]
23) Did your child feel intense helplessness?	Yes [ ]	No [ ]	Don't know [ ]
24) Did your child feel horrified; was what he/she saw disgusting or gross?	Yes [ ]	No [ ]	Don't know [ ]
25) Did your child get hysterical or run around?	Yes [ ]	No [ ]	Don't know [ ]
26) Did your child feel very confused?	Yes [ ]	No [ ]	Don't know [ ]
27) Did your child feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes [ ]	No [ ]	Don't know [ ]

UCLA PTSD INDEX FOR DSM-IV (Parent Version, Revision 1) © Page 3 of 5

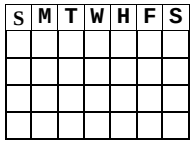
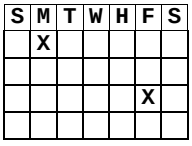
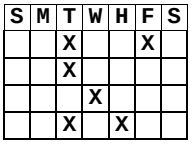
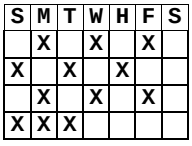
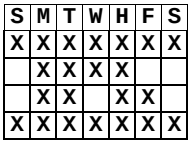
Here is a list of problems children sometimes have after very stressful experiences. Please think about your child's stressful experience that you wrote about in Question #14. Then, read each problem on the list carefully. CIRCLE one of the numbers (0, 1, 2, 3, 4 or 5) that tells how often the problem has happened to your child **in the past month**. Refer to the **Rating Sheet** (on page 5) to help you decide how often the problem has happened. Note: If you are unsure about how often your child has experienced a particular problem, then try to make your best estimation. **Only** circle "**Don't Know**" if you absolutely **cannot** give an answer. **PLEASE BE SURE TO ANSWER ALL QUESTIONS**

	None	Little	Some	Much	Most	Don't Know
1[D4] My child watches out for danger or things that he/she is afraid of.	0	1	2	3	4	5
2[B4] When something reminds my child of what happened he/she gets very upset, scared or sad.	0	1	2	3	4	5
3[B1] My child has upsetting thoughts, pictures or sounds of what happened come into his/her mind when he/she does not want them to.	0	1	2	3	4	5
4[D2] My child feels grouchy, angry or mad.	0	1	2	3	4	5
5[B2] My child has dreams about what happened or other bad dreams	0	1	2	3	4	5
6[B3] My child has flashbacks of what happened; he/she feels like he/she is back at the time when the bad thing happened living through it again.	0	1	2	3	4	5
7[C4] My child feels like staying by him/her self and not being with his/her friends.	0	1	2	3	4	5
8[C5] My child feels alone inside and not close to other people.	0	1	2	3	4	5
9[C1] My child tries not to talk about, think about, or have feelings about what happened.	0	1	2	3	4	5
10[C6] My child has trouble feeling happiness or love.	0	1	2	3	4	5
11 [C6] My child has trouble feeling sadness or anger.	0	1	2	3	4	5
12[D5] My child feels jumpy or startles easily, for example, when he/she hears a loud noise or when something surprises him/her.	0	1	2	3	4	5
13[D1] My child has trouble going to sleep or wakes up often during the night.	0	1	2	3	4	5
14[AF] My child feels that some part of what happened is his/her fault.	0	1	2	3	4	5

	None	Little	Some	Much	Most	Don't Know
15[C3] My child has trouble remembering important parts of what happened.	0	1	2	3	4	5
16[D3] My child has trouble concentrating or paying attention.	0	1	2	3	4	5
17[C2] My child tries to stay away from people, places, or things that make him/her remember what happened.	0	1	2	3	4	5
18[B5] When something reminds my child of what happened, he/she has strong feelings in his/her body like heart beating fast, head aches, or stomach aches.	0	1	2	3	4	5
19[C7] My child thinks that he/she will not live a long life.	0	1	2	3	4	5
20[AF] My child is afraid that the bad thing will happen again.	0	1	2	3	4	5
21[B1] My child plays games or draws pictures that are like some part of what happened.	0	1	2	3	4	5

FREQUENCY RATING SHEET

This form is simply an illustration to use to describe the frequency of occurrence represented by none, little, some, much, or most.

0	1	2	3	4
NONE	**LITTLE**	**SOME**	**MUCH**	**MOST**
				
NEVER	**TWO TIMES A MONTH**	**1-2 TIMES A WEEK**	**2-3 TIMES EACH WEEK**	**ALMOST EVERY DAY**

SCORING WORKSHEET FOR UCLA PTSD INDEX FOR DSM-IV, Revision 1: PARENT VERSION©

Subject ID#_____ Age_____ Sex (circle): M F # of days since traumatic event _____

CRITERION A-TRAUMATIC EVENT

Exposure to Traumatic Event
Questions 1-13: at least 1 "Yes" answer **YES** **NO**

Type of Traumatic Event rated as most distressing (Question 14: write trauma type in the blank) _____

Criterion A1 met
Questions 15-26: at least 1 "Yes" answer **YES** **NO**

Criterion A2 met
Questions 22-26: at least 1 "Yes" answer **YES** **NO**

Criterion A met **YES** **NO**

PTSD SEVERITY: OVERALL SCORE

Question # /Score	Question # /Score
1. _____	=10 or
2. _____	11._____
* 3 or	12._____
21. _____	13._____
4. _____	[Omit 14].
5. _____	15._____
6. _____	16._____
7. _____	17._____
8. _____	18._____
9. _____	19._____ [Omit 20].

(Sum the items from the above 2 columns, write sum below)

(Sum total of scores) = _____ **PTSD SEVERITY SCORE**

*Place the highest Score from either Question 3 *or* 21 in the blank above: Score Question 3. ____/Score Question 21._____
=Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____

CRITERION B (REEXPERIENCING) SX.

Question #/DSM-IV Symptom	Score	
3. (B1) Intrusive recollections or 21. (B2)Repetitive Traumatic Play	____*	
5. (B2) Trauma/bad dreams	_____	
6. (B3) Flashbacks	_____	# of Criterion B
2. (B4) Cues: Psychological reactivity	_____	Questions with Score ≥ Symptom
17. (B5) Cues: Physiological reactivity	_____	Cutoff: _____

*Place the highest Score from either Question 3 or 21 in the blank above: Score Question 3 (Intrusive recollections) _____
Score Question 21(Repetitive play) _____

CRITERION B SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION B MET:
(Diagnosis requires at least 1 "B" Symptom): **YES** **NO**

CRITERION C (AVOIDANCE) SX.

Question #/DSM-IV Symptom	Score	
9. (C1) Avoiding thoughts/feelings	_____	
16. (C2) Avoiding activities/people	_____	
15. (C3) Forgetting	_____	# of Criterion C
7. (C4) Diminished interest etc.	_____	Questions with
8. (C5) Detachment/estrangement	_____	Scores ≥ Symptom
=10. *or* 11. (C6) Affect restricted	_____	Cutoff: _____
18. (C7) Foreshortened future	_____	

CRITERION C SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION C MET:
(Diagnosis requires at least 3 "C" Symptoms): **YES** **NO**

=Place the highest Score from either Question 10 *or* 11 in the blank above: Score Question 10.____/Score Question 11.____

CRITERION D (INCREASED AROUSAL) SX.

Question #/DSM-IV Symptom	Score	
13. (D1) Sleep problems	_____	
4. (D2) Irritability/anger	_____	
16. (D3) Concentration problems	_____	# of Criterion D
1. (D4) Hypervigilance	_____	Questions with
12. (D5) Exaggerated startle	_____	Score ≥ Symptom Cutoff: _____

CRITERION D SEVERITY SCORE (Sum of above scores): = _____

DSM-IV CRITERION D MET:
(Diagnosis requires at least 2 "D" Symptoms): **YES** **NO**

DSM-IV PTSD DIAGNOSTIC INFO.

DSM-IV FULL PTSD DIAGNOSIS LIKELY
(Criteria A, B, C, D all met) **YES** **NO**

PARTIAL PTSD LIKELY
(Criterion A met and:
Criteria B + C or B + D or C + D) **YES** **NO**

Baseline Trauma Narrative Assessment

Practice Narrative

GOAL To introduce the child to writing a detailed narrative.

EXERCISE

What you need

- Writing utensils
- Blank sheet of paper

What you do

- Instruct the child to use the worksheet to write a detailed description of his or her most recent birthday.
- Instruct the child to include things that happened, as well as his her thoughts, feelings, and behaviors.
- You might have the child work on this while you meet with his or her caregiver.
- An alternative to having the child write the story is to have her tell the story to you. Encourage the child to include details about what happened, and to describe her thoughts, feelings and behaviors on that day.
- Afterward, read the narrative with the child and use it as a ‘warm-up’ for developing the baseline trauma narrative.

Baseline Trauma Narrative

GOAL **To assess the child's ability to discuss the trauma and his or her level of understanding about the trauma.**

EXERCISE

What you need

- Writing utensils
- Blank sheet of paper

What you do

- Instruct the child to use the worksheet to write a detailed description of the trauma experience. Use the specific language the child used earlier to refer to the trauma.
- Alternatively, have the child tell you about the trauma experience in as much detail as he can. Take down as much of the story as you are able to without interrupting the flow of the child's narrative.
- Instruct the child to include things that happened, as well as his or her thoughts, feelings, and behaviors.
- At this point in therapy do not provide corrective feedback about the trauma material.
- This narrative is to provide you with a baseline and is for assessment purposes.

Psychoeducation

Physical Abuse

Caregiver Information Sheet

What is physical punishment?

Physical punishment is the use of spanking, hitting, or any other form of physical discipline on a child. It is allowed by law, but can create problems. Some caregivers notice that their children cooperate the first time that physical punishment is threatened or used. Over time, however, these caregivers may have to use physical punishment more often and more intensely to get the same level of cooperation. In some cases, physical punishment may even stop working. Meanwhile, as physical punishment becomes more intense, the risk that the children will be injured increases. Injury of a child can lead to child protective services involvement or even removal of children from the home.

What is physical abuse?

Physical abuse occurs when a caregiver injures a child during physical punishment. Many caregivers do not mean to physically hurt their children. Abuse often begins as physical punishment and then escalates to the point of causing injury. This type of punishment may include hitting a child with something (such as a belt or a switch), punching, kicking, shaking, choking, burning, or stabbing. Signs of physical abuse include red marks, bruises, cuts, broken bones, or any other type of injury that occurs while a grown-up is punishing a child.

How common is physical abuse?

Physical abuse is very common. It happens across all racial, ethnic, economic, and religious groups. One out of 10 children are physically abused while growing up.

Why do caregivers use severe physical punishment or physically abuse their child?

Most caregivers love their children and don't mean to hurt them. Caregivering can be stressful, and all children behave differently. Sometimes, children may be more difficult to caregiver than at other times. It is normal for caregivers to feel angry or stressed out about their children's behaviors. When caregivers are stressed about things such as money, work, or housing, they may be more likely to get upset with their children. Many caregivers get fed up with their children's behavior and do not know any other way to discipline.

What are the effects of physical abuse on children?

When children are hit because they misbehave, they learn that hitting is an okay way to try to change other people's behavior. Physically abused children are more likely to hit their classmates, friends, and siblings. Statistics show that 4 out of 5 boys who are abused or witness domestic violence while growing up eventually go on to abuse their wives or girlfriends. Physical abuse can also cause children emotional harm by making them feel angry, helpless, guilty, ashamed, anxious, depressed, and fearful of their caregivers.

Many children who have been physically abused develop posttraumatic stress disorder (PTSD). Symptoms include, but are not limited to:

- upsetting or frequent memories or nightmares of the abuse;
- efforts to avoid thoughts, feelings, or other reminders of the abuse;
- problems falling or staying asleep, difficulty concentrating, and angry outbursts.

Because violent behavior is something that is learned, it also can be unlearned. Caregivers can reduce aggression in their children by talking about violent behavior early on and by demonstrating for them non-violent, respectful behavior. That is why it is so important for physically abused children to receive treatment.

What can caregivers do to prevent physical abuse?

It is hard, but it is also possible to break the cycle of violence. Caregivers can:

- seek help to reduce their own stress;
- learn to discipline without hitting;
- send a clear message to children that violence is unacceptable;
- teach them non-violent strategies to solve problems;
- treat their children and others with respect and kindness;
- teach their children to understand that they deserve to have positive, healthy, non-violent relationships with others.

How can treatment help families get past physical abuse?

Some mental health professionals are specially trained to help children recover from the effects of physical abuse. This kind of treatment usually involves talking about the physical abuse and learning ways to cope with the thoughts and feelings the child has about the abuse. In addition, the children's families may need to learn ways to work together at home in order to solve disagreements without the use of physical fighting. Some family therapists are trained to work with whole families, while other therapists are trained to work with the child who has been physically abused and a non-offending caregiver who is supportive of him.

Where can I go for help?

If you need help or have questions about child abuse or neglect, call the Childhelp National Child Abuse Hotline at 1-800-4-A-CHILD (1-800-422-4453) then push 1 to talk to a counselor. The hotline counselors are available 365 days a year. You can call this number if you live in the United States, Canada, Puerto Rico, Guam, or the U.S. Virgin Islands. The call is free and anonymous. The hotline counselors do not know who you are and you do not have to tell them. There will not be a charge for the call if you use a regular phone or a pay phone. In addition, your state probably has a toll-free hotline for child abuse and neglect. Childwelfare.gov has a state-by-state listing.

Physical Abuse

Child Information Sheet

What is physical abuse?

Child physical abuse occurs when a caregiver or another grown-up physically injures or hurts a child. This may be the result of a punishment such as spanking or hitting. Sometimes adults use spanking or hitting when they are trying to get children to do something, but if the child gets hurt, this type of punishment is NOT okay. This may also include hitting a child with something (such as a belt or a switch), punching, kicking, shaking, choking, burning, or stabbing. Signs of physical abuse include red marks, bruises, cuts, broken bones, or any other type of injury that occurs while a grown-up is punishing a child.

Does physical abuse happen a lot?

Yes, it occurs in many families. One out of 10 children in the United States are physically abused while growing up. You may even know another child who has been physically abused. Physical abuse can happen in any family. It does not matter what race a family is, how much money they make, where they live, or what their religious beliefs are.

Who physically abuses children?

An adult who is taking care of a child can physically abuse a child. It can be a man or a woman. Sometimes these adults have problems of their own that they take out on children without meaning to do so, but this does NOT make it right. It is important to remember that MOST adults who take care of children do NOT physically abuse children.

Why don't children tell about child physical abuse?

Children do not tell for many reasons. Some children do not tell because they are scared that their caregivers will be mad at them. Some children do not tell because they do not want the grown-up who hurt them to get into trouble. Other children may not tell because they think it is okay for a grown-up to physically hurt them in some way. But it is important that children remember it is NEVER okay for a grown-up to hurt a child.

What can happen if a child is physically abused?

At first, a child may have to deal with the pain or hurt they feel from the physical abuse. A child may have to visit a doctor or hospital for medical treatment, such as medicine for a burn, a cast for a broken bone, or surgery to repair an injury. Sometimes, children may also

be taken out of their home to live with relatives or a foster family if other grown-ups are worried that the children may be abused again.

Children may have many different feelings when they are physically abused. Some children say they feel sad, scared, lonely, and mad. Some children may feel embarrassed because they think they did something wrong and that the physical abuse is their fault. Children may be scared of the person who hurt them. Children may love the person who hurt them and be angry at the same time. No matter how a child feels, all feelings are okay!

Sometimes, children who are physically abused may have some trouble at school. They may also have a hard time getting along well with other children. However, sometimes kids who are physically abused don't have any problems at school and have lots of friends.

The most important thing to remember is that no matter what happened, physical abuse is NOT the child's fault. No matter what a child does, he should never be physically abused. Even if a child misbehaves or does something wrong, it is not okay for a grown-up to physically hurt them.

What can kids do if they are being physically abused?

Tell a grown-up that they trust, such as a caregiver, grandparent, aunt, uncle, neighbor, teacher, guidance counselor, coach, or therapist. These adults can help make sure that the child is safe.

Children can also draw pictures of what they are feeling and share them with an adult. They may also feel better by doing things that make them happy, such as drawing, reading, coloring, playing board games or video games, watching TV, playing sports, and spending time with family and friends. It is also important for children to remember that they deserve to be safe.

What can kids do if they are feeling unhappy or scared, even if they no longer live with the person who physically abused them?

Children can talk to an adult they trust about how it felt when they were physically abused and how they feel now that things are different; some of these feelings may be confusing. It is also important for children to do things that make them happy.

Sexual Abuse
Caregiver Information Sheet

WHAT IS CHILD SEXUAL ABUSE?

Child sexual abuse occurs when an adult, a much older child, or someone in a position of power forces a child to have some type of sexual contact with them. Most often, sexual abuse involves acts such as kissing, fondling, rubbing, oral sex, or penetration of the vagina or buttocks by fingers, penis, or a foreign object.

HOW COMMON IS CHILD SEXUAL ABUSE?

Child sexual abuse cuts across all racial, ethnic, religious, and economic groups. Our best estimate is that 1 in 4 girls and 1 in 6 boys are abused before the age of 18.

WHO SEXUALLY ABUSES CHILDREN?

There is no clear-cut description or profile of a sex offender, and there is no way to recognize a potential abuser. Most are men, but women are not excluded. They are often known and trusted by the children they abuse – such as a family member (e.g., cousin, uncle, caregiver, stepparent, grandparent) or other individuals familiar to the child such as a neighbor, a coach, or a babysitter. Some offenders may have been victims of abuse themselves in childhood. Some offenders find themselves more sexually attracted to children, and therefore, cannot function sexually with adults.

HOW DOES SEXUAL ABUSE AFFECT CHILDREN?

Children have different reactions to sexual abuse. A child's reaction may depend on his individual response, the reaction from his family, and the nature of the abuse. The effect is likely to be less severe if the period of abuse was brief, happened when the child was younger, and involves an offender not as well known to the child. The most important factor in the child having a successful recovery is having a caregiver who believes and supports the child once the abuse is discovered.

Once the abuse has stopped and has been revealed, it is expected that some children will return to relatively "normal," exhibiting their usual behaviors and emotions. Others, however, will continue to experience symptoms for a long time. These may include things such as bed-wetting, nightmares, wanting to be alone, difficulties in school, acting-out, or running away. Other symptoms may include talking about sex a lot, age-inappropriate sexual behavior, or fears of situations or people that remind them of the abuse.

Many children who have been sexually abused develop something called posttraumatic stress disorder (PTSD). Symptoms of PTSD include, but are not limited to:

- distressing and frequent memories or nightmares of the abuse;
- efforts to avoid thoughts, people, or settings that remind them of the abuse;
- sleep problems, difficulty concentration, or angry outbursts.

WHAT KIND OF TREATMENT IS AVAILABLE FOR CHILDREN WHO HAVE EXPERIENCED SEXUAL ABUSE?

There are many different treatments for children who have been sexually abused, but few have been tested to see if they are helpful to most children. One kind of therapy that has been tested more than others is called "cognitive-behavioral therapy" (CBT).

CBT therapists work with both the child and a non-offending caregiver because, as already stated, research shows that children recover more quickly with a caregiver's support. With CBT, the child learns facts about sexual abuse as well as new ways to relax and express himself. Also, the child shares details about abuse so that it becomes less upsetting and easier to talk about. While the child is doing this, the caregiver is learning similar things in order to reinforce lessons at home, to become more comfortable talking with her child about the sexual abuse, and to manage other emotional or behavioral problems.

WHEN SHOULD YOU SUSPECT CHILD SEXUAL ABUSE?

Many children experience guilt or embarrassment following sexual abuse. Some may also be threatened by an offender to keep them from telling. Despite these reasons, most child sexual abuse victims are identified because a child told an adult and the adult believed her. Sometimes, children accidentally reveal the abuse by demonstrating advanced sexual knowledge or behavior.

A caregiver might suspect sexual abuse if his child exhibits sudden changes in behavior such as nightmares, being alone more than usual, excessive anger, jumpiness, or inappropriate sexual behavior. One way to make it easier for your children to tell about sexual abuse is to educate them about sex and what adults can and cannot do with children.

HOW SHOULD YOU RESPOND IF YOU SUSPECT CHILD SEXUAL ABUSE?

Of course, it is natural for caregivers to be upset if they find that their child has been sexually abused, but it is important to *try to remain calm* for the child's sake. If the child observes how upset or angry the caregiver is, the child may get scared and "clam up." It is incredibly important not to blame the child for the sexual abuse; you can even congratulate her for telling you. Some children may say that they initiated the sexual contact, or that the contact felt good, but that does NOT mean that the child is to blame or should feel guilty. It is ALWAYS the *adult's responsibility* to set appropriate limits.

WHERE SHOULD YOU GO FOR HELP IF YOU SUSPECT CHILD ABUSE?

If you suspect that a child has been sexually abused you should report it to your state's department of child protective services. Most states have a 24-hour, toll-free number. You may remain anonymous when you report. The caseworker will ask you questions about the child, the possible offender, and the circumstances of the abuse. Child protective services will most likely investigate the sexual abuse allegations and provide help to the child and family. Information about child protective services in your state is likely published on your state's Internet website.

Sexual Abuse

Child Information Sheet

WHAT IS CHILD SEXUAL ABUSE?

Child sexual abuse occurs when an adult or older child touches or rubs a child's private parts (penis, testicles, vagina, bottom, breasts), or when an adult or older child asks a child to touch or rub the other person's private parts. This kind of touching is not OK. The person who does this is called a sex offender. The offender might make the child do these things and be rough, or he/she might pretend it's a game or even give the child a reward to do it. The offender could be someone known to the child – a relative, a family friend, a teenager, or another child. Still, it's not OK even if the person tries to make it fun, and the child thinks it is fun.

WHO IS SEXUALLY ABUSED?

Sexual abuse happens to a lot of children. It can happen to boys and girls of all ages, religions, and races. Some children who have been sexually abused are rich, some are poor, and they are all from different neighborhoods. 1 of every 4 girls and 1 of 6 boys may have experienced sexual abuse before they become an adult.

WHO SEXUALLY ABUSES CHILDREN?

Some people sexually abuse children, but many more people only touch children with OK touches. Most sex offenders are men, though some are women. Children cannot tell by the way these people look, dress, or act that they are offenders. Most of the time, the offender is not a stranger but someone whom the child knows very well. The offender could be a family member (such as a cousin, uncle, caregiver, or grandparent) or someone who is well known to the child (such as a coach, babysitter, or neighbor).

WHY DON'T CHILDREN TELL?

Sometimes the offender tells the child to keep the sexual abuse a secret. The offender may use tricks to keep the child from telling. The person may say that it is the child's fault or that the child or her family will get hurt if the child tells. These are all tricks. Sometimes children just keep it a secret because they feel ashamed, embarrassed, or scared. For those reasons, many children do not tell about sexual abuse, or they need a little time to gain the courage to tell. It helps the children to keep telling adults until they find an adult who will help them to stop the sexual abuse.

WHY DOES SEXUAL ABUSE HAPPEN?

There are lots of different reasons, just like there are lots of different offenders. But it's very hard to know the reason why it happens to any child. We do know this much: no child is responsible for what an adult does.

HOW CAN YOU TELL THAT A CHILD HAS BEEN SEXUALLY ABUSED?

You cannot tell just by looking that a child has been sexually abused. Sometimes you can tell by the way the child is acting that something is bothering him or her, but you do not know what it is. That is why it is so important for children to tell somebody when they experience a not OK or confusing touch.

HOW DO CHILDREN FEEL WHEN THEY HAVE BEEN SEXUALLY ABUSED?

Children may have all kinds of feelings after sexual abuse has happened. The sexual touching may feel good to some children, and they may still like the person who did it. But some children are very angry at the person who did the abuse or are scared of him. Other children might feel guilty about what happened. Any of these feelings are OK. Sometimes when people have these feelings, the feelings affect the way they behave. A child who is afraid may not want to sleep alone or be left alone. Sometimes children get into more arguments, and sometimes they may just feel sad and want to be alone. Some children feel upset for a long time after the abuse has ended, but they often feel better with the help of counseling. If children are having a hard time with these feelings, talking with a counselor or a trusted adult can help them feel better.

HOW CAN CHILDREN RESPOND TO CHILD SEXUAL ABUSE?

All children need to know that their body belongs to them. If you feel uncomfortable in the way you are being touched, you can tell the person "NO!" Saying "NO!" can sometimes be hard to do, especially if you're scared, shy, or embarrassed. But the next thing you can do is "GO" – get away from that person. And the next thing you can do is "TELL" – although this can also be hard to do, it is important to tell an adult (such as a caregiver, other family member, or a teacher) about what happened. It is important to keep telling until someone listens and helps. Remember the steps: NO-GO-TELL!

It is great to talk to a counselor or a caregiver. It helps to talk about sexual abuse, even though it can be hard. Talking, writing, and even singing and drawing can help children who have been sexually abused feel better after a while.

It is important to tell adults about child sexual abuse so that children can get help. There is a special office in every state that is available to help children who have experienced abuse.

Teri Hatcher's Story: Childhood Sexual Abuse

Teri Hatcher was sexually abused as a child. Teri Hatcher knew that telling her story could help other children who have had unwanted sexual experiences. She first told her story in 2007. Teri Hatcher was the star of the television show "Desperate Housewives." She also played Superman's girlfriend, Lois Lane, in movies. Teri Hatcher wrote that she was sexually abused many times, beginning when she was only 7-years-old. She was sexually abused by her uncle.

The Sexual abuse happened when Teri was on car rides with her uncle. Her uncle would drive the car into an empty parking lot and tell her that he wanted some private time with her. Teri felt confused. What was most confusing to Teri was that she felt two very different emotions at the same time. On one hand Teri felt shame, but on the other hand she felt excited. It is common for victims of sexual abuse to feel a mixture of emotions, good and bad.

Shame is one of the biggest reasons that children do not tell adults about being sexually abused. Teri says she wants others to know that they do not have to live with the guilt and shame and that it is never their fault for being sexually abused.

More than 30 years after her own experiences, Teri learned that a 14-year-old girl who committed suicide wrote in a note that she was sexually abused by the same uncle that abused Teri. Teri called the district attorney and found the courage to tell her story. Teri said that her uncle would take her clothes off and touch her in her private sexual area. Teri said that her uncle would ask her if it felt good. When Teri would answer, "no," her uncle would say, "well, someday it will." Teri heard these words in her mind over and over again for years. Teri said that long after the sexual abuse had happened she felt like a bad person and that she had somehow caused the sexual abuse to happen. Now she knows that it was not her fault.

The district attorney and her team used Teri's story to help convince her uncle to plead guilty to sexually abusing the girl who committed suicide. He was sentenced to 14 years in prison.

Teri thought telling her story was one of the most important things she could ever do. Her story helped stop her uncle from sexually abusing other children. "This experience," Teri said, "allowed me the space to feel validated, vindicated, and not crazy.. I was the victim. It was not my fault!"

Domestic Violence

Caregiver Information Sheet

What does "domestic violence" mean?

Domestic violence occurs when one adult family member tries controlling another adult family member with threats, hitting, sexual assault, criticism, controlling finances, limiting contact with family or friends, or destroying possessions. Domestic violence is most often caused by men who are trying to control women, although women may also initiate the violence. Domestic violence occurs in both heterosexual and homosexual relationships.

How common is domestic violence?

Domestic violence occurs across all racial, ethnic, religious, and economic groups. Every year, there are about 1 million women who report being victims of domestic violence. This means that about 3 million children witness domestic violence each year. However, these numbers only reflect those cases that are reported. Many instances of domestic violence do not get reported to law enforcement.

How does domestic violence affect children?

Usually, when we think about domestic violence, we think about the person who does the hurting and the person who gets hurt. But it is important to remember that children are also affected by domestic violence. Children who witness domestic violence are more likely to be abused themselves. In fact, about half of people who abuse their spouses also abuse their children. Also, children who witness domestic violence are more likely to be angry, aggressive, defiant, depressed, or anxious. They are less likely to want to be with friends or to have a best friend. In addition, they worry more about the safety of others.

Some children who witness domestic violence develop posttraumatic stress disorder (PTSD). Symptoms may include:

- upsetting or frequent memories or nightmares of the violence;
- efforts to avoid thoughts, feelings, or other reminders of the violence;
- problems falling or staying asleep, difficulty concentrating, and angry outbursts.

Children who witness domestic violence are more likely to grow up abusing drugs or alcohol, committing sex crimes, being violent, being victims of domestic violence, and entering the criminal justice system.

Which symptoms of domestic violence are easier to notice in children?

- bullying, aggressive behavior, and insulting their peers;
- avoiding contact with other kids;
- difficulty separating from a caregiver;
- being defiant with authority figures;
- displaying behaviors that are younger than typical for their age;

- academic and behavioral problems at school;
- nightmares or difficulty falling or staying asleep;
- running away from home;
- acting like a caregiver at home.

Which symptoms of domestic violence are easier to notice in teenagers?

- being the abuser or being abused in a dating relationship;
- acting like a perpetrator of domestic violence (e.g. threatening);
- displaying a need to protect the victim of domestic violence;
- drinking or using drugs;
- engaging in risky behaviors;
- hanging out with peers who participate in risky behaviors.

Which symptoms of domestic violence in children might be less noticeable?

- nervousness, anxiety, or fear;
- depressed mood and suicidal thoughts;
- excessive worry about the safety of others;
- embarrassment (not wanting others to know about family violence);
- resentment toward the abused caregiver and other family members;
- fear that everyday arguments will turn into violence;
- fantasies of standing up to, or hurting the abuser;
- wanting to be powerful (like the abuser);
- confusion regarding "loyalty" to both the abusive and abused caregivers.

Who is responsible for domestic violence?

An offender is a person who controls his partner with threats, physical violence, and/or sexual assault. When a batterer is violent toward a partner, he is responsible for exposing any children in the home to this violence. Domestic violence does not often stem from anger, impulses, or drinking problems that can be treated with counseling; it usually comes from a desire to control others. It is rare that mental health treatment will stop them from trying to obtain control.

How can I help my child?

- tell him that the abuser's behavior is wrong;
- reassure her that none of the violent episodes were her fault;
- remind him how much you love him;
- develop a safety plan to prepare for crisis situations;
- encourage her to talk openly about her feelings;
- be prepared to get extra help for your child's schooling if he needs it;
- seek help from a mental health professional.

Domestic Violence

Child Information Sheet

What does "domestic violence" mean?

Domestic violence means that one adult family member is hurting another family member. For example, when an adult pushes, shoves, hits, slaps, punches, or uses a weapon against another family member, we call that domestic violence. Usually, the pushing or hitting is being used to force a family member to do something she does not want to do, or stop her from doing something that she wants to do. This can all seem very scary. The most important thing to remember is that when adults fight, it is never the child's fault. Of course, children wish that they could stop adults from fighting in their home, but they just cannot -- no matter how good they are.

Do a lot of kids see and hear domestic violence in their homes?

Yes. More than 3 million kids see this violence in their homes every year. There are a lot of children who see and hear adult family members hurting one another.

What can kids do to help themselves when they see or hear this kind of violence in their homes?

- When there is no fighting going on, they can talk to their caregivers or caregiver about how it feels when one adult is hurting another;
- Plan with their caregivers to have a "safe" place where they can go when their caregivers are fighting;

- Come up with a safety plan with their non-abusing caregiver in case of emergencies;
- Talk to a grandparent, aunt or uncle, a grown-up friend, a friend's caregivers, or a family helper about how they feel when their caregivers or other adult family members fight;
- Draw pictures of what they are feeling;
- Do things that make them happy, such as reading favorite books, playing board games or video games, watching TV shows, and talking to friends on the phone (or visiting them);
- Remember that they are not the reason one caregiver or caregiver is abusing the other.

What can kids do if they are feeling unhappy or scared, even if they no longer live with the person who was violent?

- Talk to the adult who got hurt by the domestic violence or to another trusted adult about how it felt when they saw or heard the violence in their home;
- Talk to the adult that got abused or other trusted adult about how it feels now that things are different, even if the feelings are confusing;
- Talk to a teacher or a counselor about all these confusing feelings;
- Do things to help themselves feel happy, such as drawing, reading, coloring, playing board games, playing video games, watching TV, playing sports, and spending time with family and friends;
- And always remember: no matter what happened between the caregivers or adults that were fighting, it was not the child's fault.

Community Violence & Bullying

Caregiver and Child Information Sheet

Many kids and teens see violence every day. Some kids see it on TV. Some kids see it in video games. Others see it in their neighborhoods or at school. Many kids and teens are involved in these violent acts. Some do the hurting. Others end up hurt.

Did You Know!

In 2004, over 780,000 people between the ages of 10 and 24 were seen in hospital emergency rooms for injuries received as a result of violence. About 1 out of 5 teens between the ages of 12 and 17 are victims of serious violent crimes . About 1 out of 3 high school students get into a physical fight. Of those students, 1 out of 9 need medical help. About 1 out of 6 kids in grades 6-10 have been bullied and 1 out of 12 kids in these grades say they are bullied at least once every week .

How do bullies hurt others?

There are many ways bullies hurt others. Bullies might tease with words. They might use the internet posting insults in a chatroom. They might repeat rumors and gossip. They might steal belongings or vandalize property. Or, they might use physical violence like hitting, kicking, or shoving.

How are victims affected?

- serious injuries requiring medical attention;
- constant worry by victims;
- being unable to focus on schoolwork and then their grades might suffer;
- mental health problems including depression, anxiety, posttraumatic stress disorder (PTSD), and substance abuse;
- victims may become increasingly aggressive and get into trouble at school or in the community;

What can you do when you see violence or are bullied?

- attempt to escape or avoid the situation;
- find a trusted adult who might help you;
- seek help from trusted friends;

Traumatic Grief

Information Sheet

It is normal for children to grieve after the death of a loved one. Grieving children typically feel very sad and may have trouble sleeping, feel less hungry and eat less, lose interest in spending time with family and friends, feel irritable and withdrawn, have trouble concentrating, and may be preoccupied with death. Some grieving children may also develop physical complaints or regress back to behaviors they had outgrown, like bed-wetting or clinging to caregivers.

However, some children develop a condition called traumatic grief, which is different from the normal grieving process. Children whose lives are already very complicated and filled with challenges may be particularly likely to develop traumatic grief reactions. Children with traumatic grief often:

- **experience significant distress even three months after the death;**
- **think of the death as horrifying or terrifying;**
- **have trouble carrying out activities of daily living;**
- **experience nightmares and significant sleep problems;**
- **feel guilty about the death and blame him or herself;**
- **complain of physical symptoms like headaches and stomachaches;**
- **become anxious or worried;**
- **have frequent thoughts or reminders about the way the person died;**
- **show a significant drop in school performance;**
- **become extremely irritable and angry;**
- **have a hard time adjusting to changes in their lives;**
- **not accept the reality and permanence of the death;**
- **withdraw and lose interest in spending time with friends and family.**

It Happens to People you Know

GOAL **To help the child to understand that trauma happens to all kinds of people**.

EXERCISE

What you need

- **The "It Happens to People You Know" Worksheet**

What you do

- **Discuss with the child the fact that trauma happens to all kinds of people and that she is not the only one.**
- **Have the child look at the list of names of famous people on the It Happens to People Worksheet.**
- **Tell the child that all of the famous people on the worksheet have experienced trauma.**
- **Ask the child to choose someone she finds interesting - or if you or the child know a different well-known person who is not on the list you can use that person.**
- **Have the child look up information about the person he or she chooses on the internet using a search engine like Google.**
- **Encourage the child to see what he or she can learn about how this person sought help after the trauma.**

HOMEWORK

For the child

- **Ask the child to write a letter to the person he or she chose to learn more about.**
- **Younger children may draw a picture instead of the letter.**
- **Ask the child to praise the person he or she chose for sharing their traumatic experience and for working so hard to overcome the consequences of trauma.**
- **The child may or may not decide to actually mail the letter or picture.**

For the caregiver

- **Ask the caregiver to be aware of other people in the news or on television who have experienced trauma and who have told their story.**
- **Ask the caregiver to think about the different ways in which traumatic experiences affect people, both adversely and positively.**

It Happens to People You Know Worksheet

TOM ARNOLD
ROBERTI BLAK
DREW CAREY
BILLY CONNOLLY
DEREK LUKE
TYLER PERRY
CASPER VAN DIEN
ALISON ARNGRIM
ROSEANNE BARR
DREW BARRYMORE
HALLE BERRY
DELTA BURKE
BRETT BUTLER
ANGIE DICKINSON
FRAN DRESCHER
ANNA MARJE
PATTY DUKE
FARRAH FAWCETT
TERI HATCHER
GOLDIE HAWN
ANNE HECHE
KELLY MCGILLIS
ROSE MCGOWAN
ROSIE O'DONNELL
TATUM O'NEAL
CATHERINE OXENBERG
ROSIE PEREZ
SUZANNE SOMERS
GABRIELLE UNION
CINDY WILLIAMS
LAVERANUES COLES

THOMAS HENDERSON
SHELDON KENNEDY
GREG LOUGANIS
ROY SIMMONS
ESERA TUAOLO
CHRIS WITTY
MAYA ANGELOU
ANTWONE FISHER
GEORGE ORWELL
ALEXANDER PUSHKIN
ALICE SEBOLD
ANNE SEXTON
ANGELA SHELTON
ALICE WALKER
VIRGINIA WOOLF
ELLEN DEGENERES
RAIN PRYOR
HENRY ROLLINS
MARILYN VAN DERBUR
TARA CONNER
JANICE DICKENSON
CHRISTINA AGUILERA
TORI AMOS
LUDWIG VAN BEETHOVEN
CHESTER BENNINGTON
MARY J. BLIGE
JOHANNES BRAHMS
TONI CHILDS
JONATHAN DAVIS
ELLA FITZGERALD
SOPHIE B. HAWKINS

BILLIE HOLIDAY
MARILYN MANSON
MEAT LOAF
MISSY ELLIOT
SINEAD O'CONNOR
OZZY OSBOURNE
MARIE OSMOND
QUEEN LATIFAH
AXL ROSE
CARLOS SANTANA
B. J. THOMAS
PETE TOWNSHEND
TINA TURNER
BILL CLINTON
OPRAH WINFREY
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Helping Caregivers Talk to their Child about the Trauma

GOAL **To help the caregiver develop skills to talk to their child about the trauma.**

EXERCISE

What you need

- **The "Talking to Your Child about the Trauma" Handout**

What you do

- **Ask the caregiver about times he and his child discussed the traumatic event. Who brought it up? How did the caregiver respond? What was the subject matter? What kinds of feelings were expressed?**
- **Carefully review the information on the handout, eliciting the caregiver's feelings and thoughts about talking to his child about the traumatic event.**
- **Engage the caregiver in brief role-plays to practice some of the guidelines on the handout.**

HOMEWORK

For the caregiver

- **Ask the caregiver to be mindful of times her child raises the topic of trauma and, if possible, make time to listen to the child and answer any questions he may have.**
- **Remind the caregiver not to pressure the topic but to follow the child's lead.**
- **Encourage the caregiver to praise the child for sharing his thoughts and feelings about the trauma.**

Talking to Your Child about the Trauma

A Handout for Caregivers

You can help your child better process emotions and thoughts about the trauma by being receptive to discussion about the trauma outside of therapy sessions. Facilitating trauma-related discussion provides more opportunities for children to better understand their experiences and cope with trauma reminders.

Here are some helpful guidelines:

- Explore your personal feelings about your child's trauma before talking to your child. Anticipate your reactions and think about how they may affect your child. You might do this by sharing your feelings with other adults or professionals.
- Work on reducing your avoidance of trauma-related discussion and show your child that you are willing to talk openly about it.
- Encourage trauma-related discussion gradually. For example, start with discussions that are more general (e.g., how someone else who experienced sexual abuse might feel), slowly moving towards discussion about the child's personal experience (e.g., how the child feels about being sexually abused).
- Use age-appropriate materials. Books, art materials, and web resources may be helpful in initiating and maintaining discussion.
- Use open-ended questions. Sometimes caregivers ask questions that unintentionally encourage children to feel as if they did something wrong. To

avoid encouraging feelings of shame or self-blame, ask questions in ways that are supportive and open-ended. Examples of open-ended, supportive questions and unhelpful questions include:

GOOD Tell me about what happened with (name of offender). What happened next? How did you feel when that happened? What did you think when that happened?

BAD Why did you let him do that?

GOOD What did (the offender) say to you? How did you feel when he told you to do that?

BAD Why didn't you tell me (sooner)?

GOOD Most children never tell about (sexual abuse). I am so proud of you for telling. What made you decide to tell when you did? What kept you from telling at first?

Adapted from Deblinger and Stauffer (2004) UMDNJ-SOM CARES Institute

Vignettes

GOAL **To generate discussion about trauma and traumatic stress.**

EXERCISE

What you need

- **The five "Vignette" Worksheets**

What you do

- **Choose the vignette that is most similar to the trauma the child has experienced and is focusing on in therapy.**
- **Read the vignette together with the child.**
- **Use the questions at the end of each section to talk about the character's experiences.**
- **Do not pressure the child to talk about his or her own trauma. Instead, allow the discussion to focus on the character and the vignette at this early stage in therapy.**
- **You might want to create your own vignette using the blank Vignette #5**

Vignette 1
About a boy physically abused by his stepfather.

Vignette 2
About a girl who comes home to find her father after he has died of a heart attack.

Vignette 3
About a girl who witnesses domestic violence.

Vignette 4
About a boy who witnesses community violence.

Vignette 5
Be creative and create a customized vignette.

Vignette # 1

Jake is a 12-year-old boy who lives with his mom, dad, and three sisters. Sometimes when his mom and dad would get into fights, his dad would get angry with Jake and start hitting him and punching him in the face for no reason. This would happen at least twice a week. Sometimes when Jake would start to hear his caregivers yell, he would go to his room, close his door, and try to watch TV shows he liked. Jake also tried to block out all loud noises, like kids shouting in the school cafeteria at lunch, or the referee's whistle at his soccer games. In fact, when Jake would hear loud noises like that, he would get really scared, and he would remember his dad hitting him over and over. Because Jake got so upset at these noises, he started skipping school right before lunch and stopped going to his soccer practices. He even stopped playing video games with his friends because he didn't like the loud noises and that the characters would try to beat each other up.

- What kinds of things is Jake missing by stopping all of these activities?
- What kinds of feelings will Jake have if he tries to do these activities?

Jake's Aunt Mary noticed that Jake had stopped telling her about all of his soccer games. Aunt Mary asked him what was wrong, and he finally told her about stopping all of his fun activities because he didn't like loud noises. Aunt Mary told Jake she would go to a soccer practice with him and try to help him if he got scared. Jake and Aunt Mary went to his next practice and he was really happy about seeing all of his soccer buddies he hadn't seen in a whole month. When his coach blew his whistle, he got nervous and looked over at Aunt Mary. She gave him a big smile and he felt better.

- Why do you think Jake felt better?
- What do you think will happen if Jake keeps going to practice?

Soon, Jake started going to the school cafeteria again. Even though he didn't like the loud yelling and talking, he sat down with a bunch of his friends and tried to think about just talking to them. Every day he would think about something to talk about with his friends so that he wouldn't concentrate on just the loud noises. Soon, he was able to concentrate on talking to his friends and not think about how loud it was in there. And when his friends started telling him they wanted him to hang out and play video games more, he decided to try it again. This time, he brought games that he liked that made him feel good. He started getting really excited every time he was invited to come over to play video games.

- How was Jake able to start doing his activities again?
- How does Jake feel now that he is doing his activities again?

Vignette #2

Alicia is a 16 year old girl who lives with her mother and father. Both of Alicia's caregivers worked until late, so she would always walk home from cheerleading practice and make herself dinner. One day, Alicia came home from cheerleading practice and noticed that some things on the tables were all over the floor. She walked into the living room and found her father lying on the floor. Alicia ran over to her father, but he didn't look like he was breathing. Alicia immediately called 911 and an ambulance came. Alicia went with the ambulance to the hospital with her father. At the hospital, Alicia called her mother, who came over right away. After waiting for a long time, a doctor came out and told Alicia and her mother that her father had suffered a heart attack and died.

- Name some thoughts Alicia might have in the moment when she hears her father died.

After the funeral, Alicia didn't want to wake up every morning because she missed her dad so much. She felt like she couldn't breathe. Alicia's mom didn't leave the house and would spend all day crying in her room. There was a big cheerleading competition coming up in a couple of months. Alicia had been really looking forward to it, but now that her dad was gone, she didn't care about anything.

- Should Alicia go to the competition? Why or why not?

Alicia's grandmother would come over to the house every day to help with the cleaning and cooking, because her mother would not leave her room. Eventually, Alicia started helping her grandmother cook dinner. At first, they didn't say much to each other, but soon they starting talking about Alicia's dad and the meals he liked to eat. Talking about her dad made Alicia feel really sad, but also really happy because she didn't want to forget him.

- Should Alicia try to help her mother? What would you do if your mom or dad was so depressed that they could not leave their room?
- Do you think talking about a person who has died is helpful or not? Why?

How would you write the ending to Alicia's story?

Vignette #3

Shay is a 10-year-old girl who lives with her mother and her mother's boyfriend, James. Shay did not like being at home because James got angry a lot and would fight with her mother. Sometimes Shay saw James hit her mom in the face. Once, when Shay was trying to watch TV, her mom and James were fighting and James pushed her mom down the stairs. Shay ran to her mom to see if she was alright, but her mom told her to go to her room and lock the door. Shay could hear her mom and James screaming at each other for the rest of the night.

- How do you think Shay feels hearing her mom and her boyfriend fighting with each other?
- What thoughts do you think went through Shay's mind when she saw her mother being pushed down the stairs?

Shay did not like going to school because when she thought about her mom getting hurt she would cry a lot and want to go home to see if she was okay. Sometimes Shay would pretend to be sick so that she could stay home from school. Soon, Shay was getting F's on her tests because she couldn't concentrate on studying or she wouldn't get her homework done.

- What do you think will happen if Shay keeps staying home from school?
- What kinds of things can Shay do if she worries about her mom?

Shay's teacher, Mrs. Smith, was worried about Shay's grades and talked to her about it. Shay told Mrs. Smith that she was worried about her mother when she was at school. Mrs. Smith invited Shay's mother to come talk about it after school one night. They decided that if Shay was worried next week, she would be allowed to call her mom from school, but Shay would have to go to school every day for the whole week. Shay tried it out and called her mom two times the next week. Both times Shay's mom said she was okay. Shay felt better. Shay stopped missing so many classes and her mom helped her with her homework at night. Shay started getting good grades on her tests again. Sometimes James would still yell, but the next time he hit her, Shay's mom called the police. The police came and took James away.

- How does Shay feel when she calls her mom?
- Why do you think Shay started doing better in school?

Vignette #4

Darryl is a 15-year-old boy who lives in an apartment in the city with his mom and older brother. Darryl did everything with his older brother, including helping him sell drugs. One day, Darryl was standing with his older brother and a couple of his friends on the corner when a car came by and started shooting at them. As Darryl was running away, he saw his friend Mike fall to the ground and start screaming. But Darryl was so scared, he didn't stop running. A couple of minutes later, some people started coming out of their houses and ran to where Mike was, while Darryl watched from behind a building. Soon, the police came and took Mike away on a stretcher. Darryl's brother told him later that night that Mike had been shot and died at the hospital.

- How do you think Darryl feels after finding out that Mike died?

For months after Mike died, Darryl didn't want to leave his apartment. The corner where the shooting occurred was just a block from his place, and Darryl had to pass it to go to school. Darryl started having nightmares about hearing Mike screaming and the car coming toward him and shooting at him, but he was unable to run away. Every time Darryl's brother left the apartment, Darryl became really worried and felt like he was going to throw up. Darryl stopped going to football practice because the field was across the street from the corner where the shooting happened.

- Why doesn't Darryl want to leave his apartment?
- Why does Darryl feel sick when his brother leaves the apartment?

Darryl's football coach, Mr. Brown, called Darryl to find out why he was missing practice. Darryl told him he didn't feel like playing anymore and just wanted to stay in his apartment. Mr. Brown told him his friends on the team were asking about him. Darryl said he'd think about going to practice again.

- What do you think Darryl needs to do to be able to go back to practice again?
- How would you write the ending of this story?

Vignette #5

What is Posttraumatic Stress Disorder?

Many people experience very stressful or traumatic events in their lives.

Traumatic events include being in an accident, seeing a violent death, being attacked, being physically or sexually abused, or seeing a dangerous fight.

Anyone who experiences a very stressful or traumatic event can develop posttraumatic stress disorder (PTSD).

In fact, about half of all people who experience a traumatic event get PTSD. That is like a flip of a coin.

Someone who has PTSD is affected by the traumatic event even 3 months after it is over.

For example, during a traumatic event your body goes into alarm mode. Your heart beats faster. You sweat. You might tremble. Your body is preparing to either run from danger or to protect yourself.

Someone with PTSD cannot turn off the body's alarm system, so that person's body is acting like there is danger even after the danger is all gone.

There are 3 ways your body might act if you have PTSD.

1. You might have thoughts about the traumatic event or imagine the trauma by seeing or hearing things that happened even when you do not want to. Sometimes you

might even feel like you are back in time, experiencing the traumatic event over again. These disturbing thoughts may interfere with things you like to do.

2. You might avoid things that remind you of the traumatic event, even if they are not dangerous. For example, if you saw someone get violently attacked in school you might avoid going to school because it reminds you of the trauma. You also might stop doing things that you used to enjoy because they remind you of the trauma.

3. You might feel overly alert or jumpy. You might spend a lot of time looking out for danger. You might spend so much time being super alert or overly cautious that you miss out on things you used to enjoy.

Trauma-focused therapy helps people with PTSD to turn off their body's alarm system and to stop these 3 things from happening to them so they can live a happy life.

In order for therapy to work, people with PTSD must be willing to talk about the trauma with the therapist. By talking about the trauma in therapy, people with PTSD might find that they slowly stop having these 3 things happen to them.

Treating PTSD: Turning on the Light

GOAL **To help the child to better understand why talking about the trauma makes it less distressing and more manageable.**

EXERCISE

What you need

- **The "Turning on the Light" Worksheet**

What you do

- **Fold the worksheet in half in order to show the child one face at a time.**
- **Show the child the scary face with the light off (left face) and then with the light on (right face).**
- **Discuss how 'turning on the light' makes the scary face less scary. Use this analogy to explain why talking about the trauma makes it less distressing and more manageable.**

HOMEWORK

For the child

- **Ask the child to show his or her caregiver the faces on the worksheet and explain how shining the light on scary things makes them less scary.**

For the caregiver

- **Ask the caregiver to look for other examples of how "turning on the light" makes stressful things more manageable.**

Turning on the Light

Fold here

Fold here

PTSD Avoidance Exercise

GOAL **To help the child to understand how trauma can lead to avoidance symptoms**.

EXERCISE

What you need

- **The "Dolly the Goldfish" Worksheet**

What you do

- **Dolly is a goldfish character who has experienced a scary, traumatic event and whose life changes afterward.**
- **Read Dolly's story with the child and then discuss how Dolly's life has changed and what she might do to make it better.**
- **Read the instructions on the worksheet with the child.**
- **Ask the child to finish the story of Dolly and to illustrate the story by filling in the blank squares.**
- **For example, the story might finish with Dolly leaving her tank and re-exposing herself to the lake until she is able to do the things she used to enjoy.**
- **If it is an older child you are working with you might tell him or her that he or she is finishing a children's book to use with younger children who have experienced trauma.**
- **Use this exercise to discuss avoidance and how one might address this problem.**

HOMEWORK

For the child

- **Ask the child to tell her caregiver the story of Dolly using the completed worksheet.**

For the caregiver

- **Ask the caregiver to discuss the story of Dolly and share ways in which a scary experience may have stopped him from doing something he used to enjoy.**

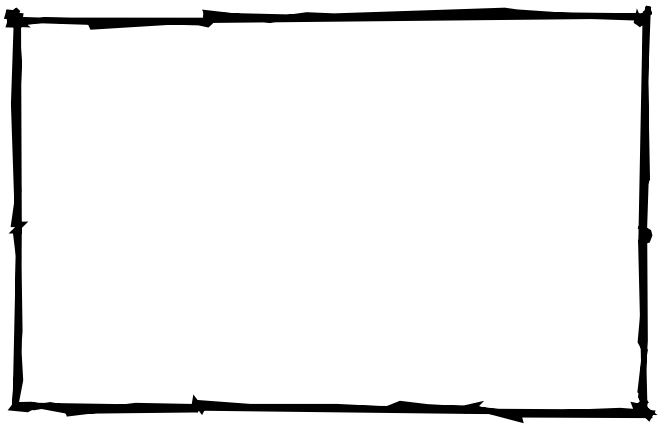
DOLLY THE GOLDFISH

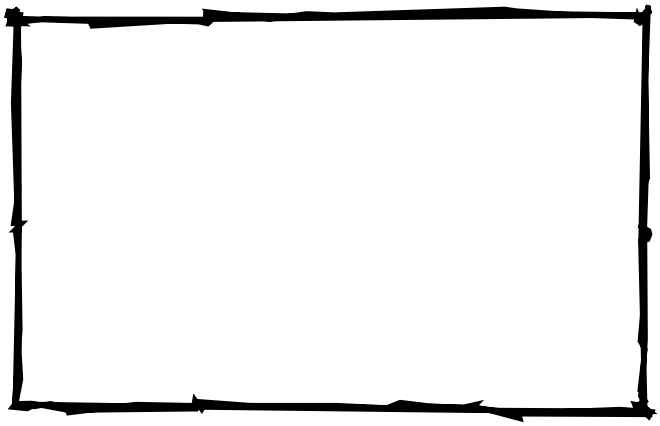
Dolly the goldfish
Lived in a lake
The largest, coolest, sweetest lake
Where she loved to explore and
Navigate.

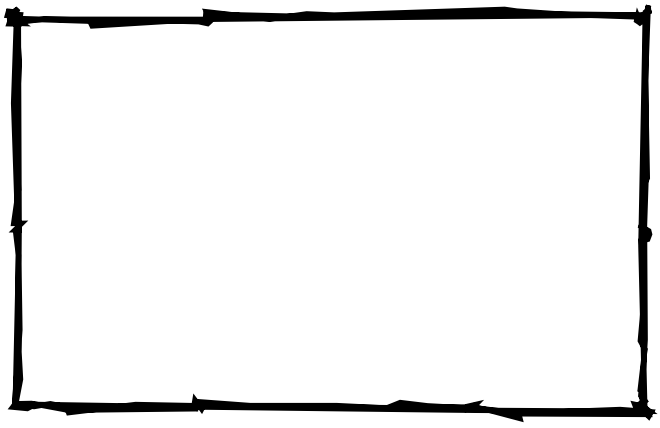
One day a boat
Stirred Dolly awake
She noticed a worm
Fall into the lake
Dolly swam up
And swallowed the worm
Unaware of the fact
The worm was a fake.

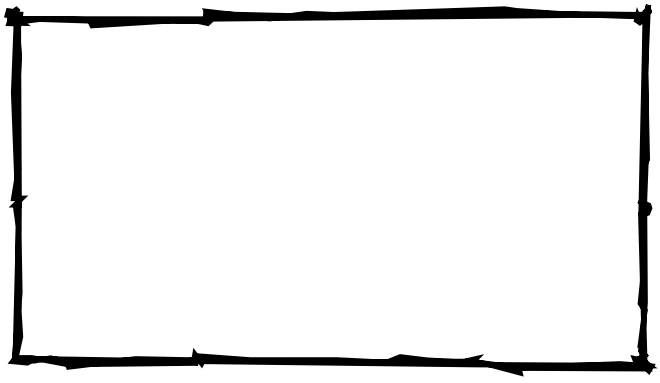
Ouch! said Dolly
Stuck on a hook
Dragged up to the surface
For fishermen to look
In pain and scared
Dolly's fins shook
Held by a human
Who pulled out the hook.

Wiggling and jiggling
Dolly escaped
Still shaking and scared
Bent out of shape
For days, weeks
on the bottom of the lake
Dolly worked hard
and built her own fish tank.



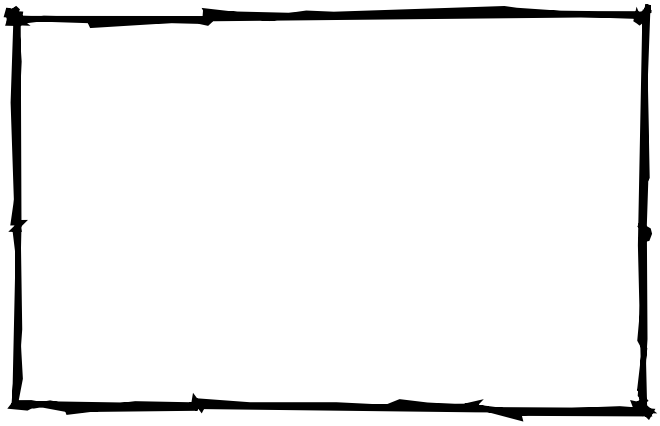


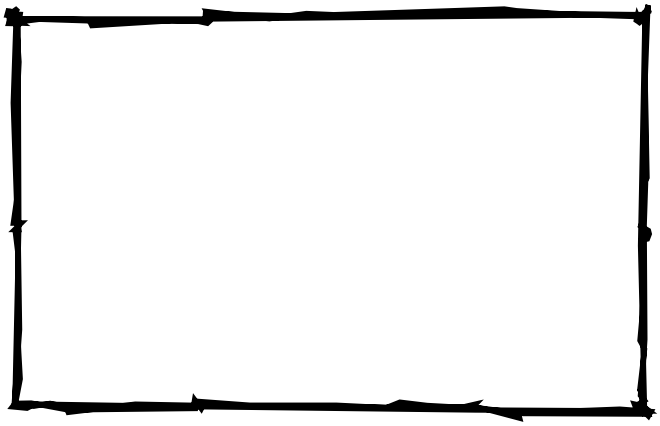


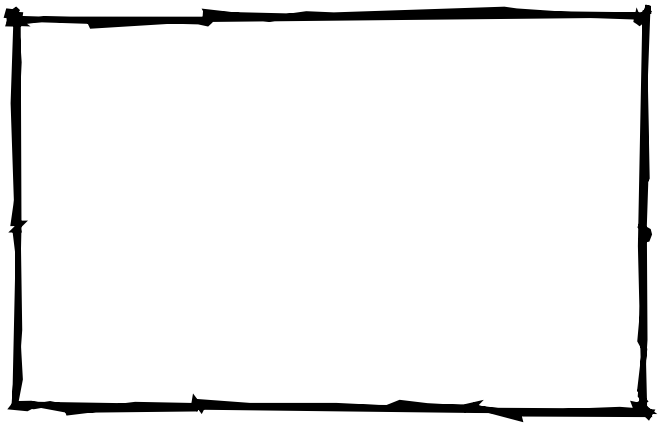


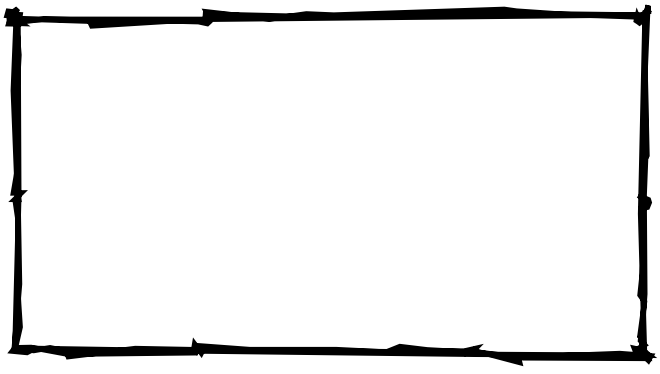
She lived inside
Never leaving the tank
Afraid of outside
And of that great lake.

Days passed by Dolly
Missing out on life's fun
She stopped exploring
Stopped visiting the sun
For fear of the hook
Never leaving the tank
Her exploring was done
Stuck under the lake.









PTSD Hyperarousal Exercise

GOAL **To help the child to understand how trauma can lead to hyperarousal.**

EXERCISE

What you need...

- Loud alarm clock
- Paper and pencil

What you do

- Discuss with the child the PTSD symptom of hyperarousal.
- Ask the child to play a game that will illustrate how this symptom works.
- Tell the child that you are going to read a list of words and that you are going to ask him or her to recall the words to see how many he or she can remember.
- Read the list of words below (or a list that you create) slowly, about one second each.
- About one minute after you read the words, ask the child to recall them. You might set a time limit for the recall.

  Basketball, Teapot, Apple, Library, Pineapple, Desk, Bucket, Sunshine, Rain

- Praise the child for doing a good job.
- Now, tell the child that he or she will be doing the same thing while an alarm clock is going off.
- Turn the alarm clock on and read a different list of words in the same fashion (about one second each).

  Baseball, Table, Fruit, Book, Elephant, Beach, Cloud, Flower, Banana

- Wait one minute and then have the child recall the words while the alarm clock is still going off. Set a time limit for the recall.
- The child should have done worse in the second round because of the distraction of the alarm.
- Explain to the child that people with PTSD sometimes feel like they have a constant alarm going off in their heads and bodies. Explain that this constant alarm can distract them from doing daily activities, like schoolwork.

PTSD Reexperiencing Exercise

GOAL **To help the child to understand how trauma can lead to reexperiencing.**

EXERCISE

What you need

- Paper and pencil

What you do

- Discuss with the child the PTSD symptom of reexperiencing the traumatic event.
- Ask the child to play a game that involves imagination.
- Ask the child to close his or her eyes and to imagine a white bear. Tell the child to try to make the bear as vivid and as real as possible.
- Ask the child to describe the white bear to you.
- Then, tell the child to open his eyes but to still think about the white bear.
- After a couple of minutes, ask the child to use each letter in his name to think of a different animal that is not a bear. Instruct the child not to think of the white bear any longer.
- Tell the child to try to block the white bear out of his mind.
- Tell the child to count the number of times the white bear pops into his mind while doing the name task. You might have the child make check marks at the bottom of the paper each time he thinks of the white bear.
- Later, discuss how many times the white bear popped into his head.
- Point out that the more he tried not to think about the white bear, the more it likely popped into his mind.
- Explain that this phenomenon is similar to when thoughts about the trauma seem to pop into one's mind when that person tries very hard not to think of them.

Notes

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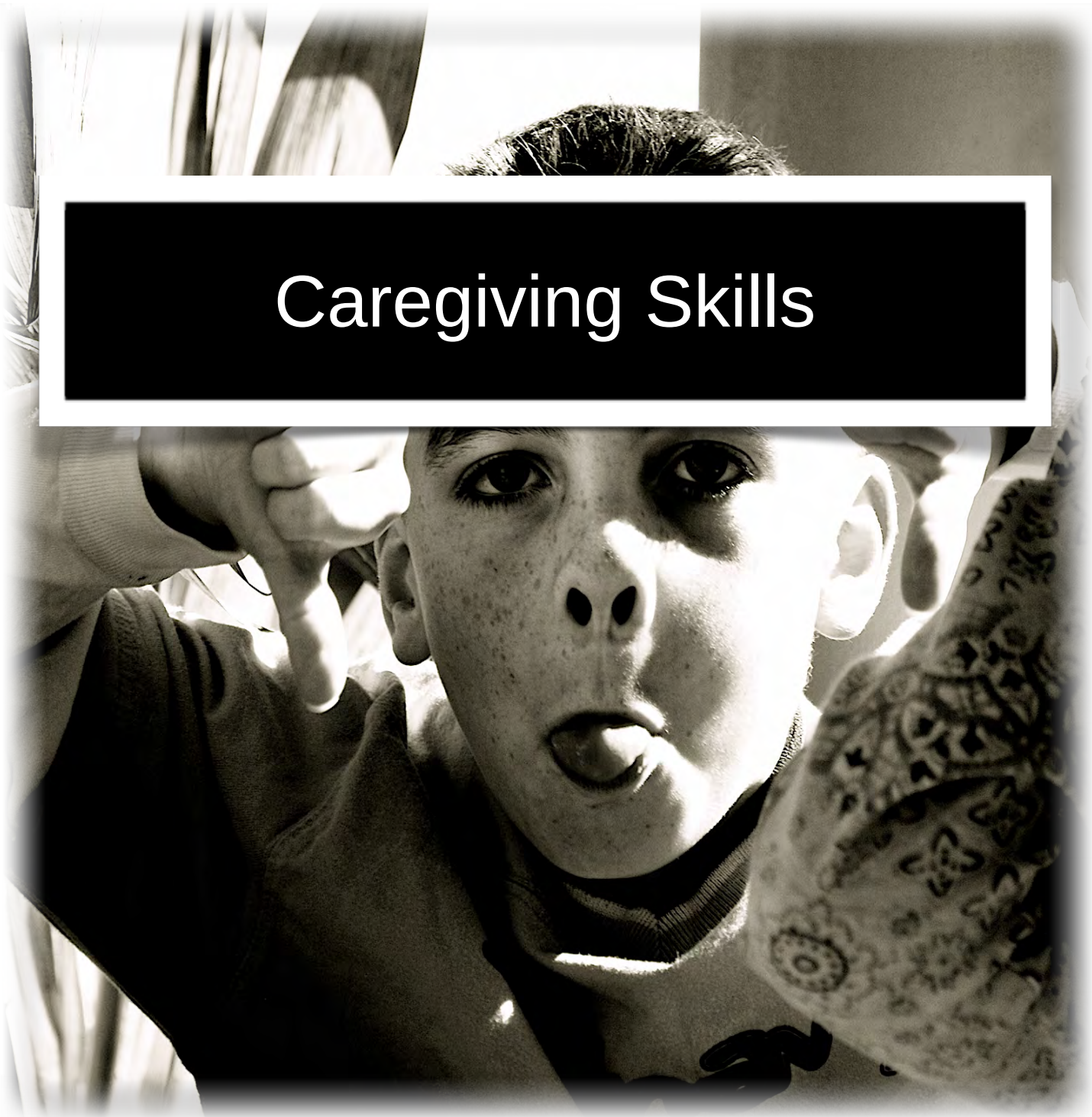


Caregiving Skills

Praise It

GOAL **To help caregivers practice using praise and recognize the difference between using positive and negative reinforcement.**

EXERCISE

What you need

- Picture to color in
- Crayons
- The "Praise It" handout for caregivers

What you do

- Ask the caregiver to engage in a role-play.
- Instruct the caregiver that you will play the "child."
- Explain that you are going to work on coloring a picture and that you (the child) are allowed to use any color you want but that you must stay within the lines and must color in shapes fully.
- Instruct the caregiver to try using both positive and negative reinforcement. First, have the caregiver point out when you "break the rules" and to warn you of possible consequences (make them up).
- After spending some time with the negative reinforcement, have the caregiver instead use positive reinforcement by praising you when you are coloring within the lines and coloring shapes fully.
- Have the caregiver note the differences in the way using each type of reinforcement makes him or her feel.

HOMEWORK

For the caregiver

- Ask the caregiver to practice using positive reinforcement and praise in real-life situations with his or her child in the coming week. Ask the caregiver to keep track of any changes in the way his or her child behaves as a result of using this strategy.

Praise It

A Handout for Caregivers

Caregivers often are unaware of the powerful influence their attention can have on their children's behaviors. This influence can best be appreciated when you begin to provide positive attention more effectively and more systematically in the form of praise. Consider the following guidelines.

GUIDELINES:

1. As soon as you notice the desired behavior, praise it.
2. Use consistent praise.
3. Your child should predict when you will be offering praise.
4. Use specific language and be as direct as possible.
5. Do not tag negative ad-ons to praise (e.g., Now why not do that all the time...).
6. Be enthusiastic but realistic when you praise.
7. Smile.
8. Praise specific behavior and effort. Avoid superlatives.
9. Do not wait for the positive behavior to be performed to perfection, praise your child's steps or efforts towards accomplishing the behavior.
10. Offer global praise, too - such as: I love you. I'm so blessed to have you. I'm so proud to be your mom. This type of praise is very important as it reassures children that they are unconditionally loved.
11. Praise the desired behavior as enthusiastically as possible. Children's negative behaviors often receive loud, exaggerated caregiveral responses. Try responding to positive behaviors with similarly loud and exaggerated displays of positive attention.

Adapted from Deblinger and Stauffer (2004) UMDNJ-SOM CARES Institute

Active Listening

GOAL **To help caregivers understand and practice active listening.**

EXERCISE

What you do

- **Ask the caregiver to engage in a role-playing exercise. Instruct the caregiver to tell you about the thing that he or she feels most enthusiastic about (e.g., hobby, activity).**
- **Instruct him or her to talk to you about it for about five minutes.**
- **When he or she begins to talk start to engage in another task, like organizing files or writing notes. Make little eye contact. Nod when appropriate. Grunt.**
- **After five minutes are up ask the caregiver how he or she felt after telling you about his or her passion.**
- **After you and the caregiver have discussed her reaction to your partial and inadequate attention, ask the caregiver to try again using the same or a different topic to talk about. This time use active listening throughout the five minutes.**
- **Afterward, ask the caregiver how he or she felt. Engage the caregiver in a discussion about how often he or she notices himself or herself using active listening with his or her child.**
- **You may want to gauge how much you decide to disengage from the caregiver during the role-play exercise by your therapeutic rapport with the caregiver. Be sensitive to how the caregiver may react to your disengagement despite the fact that it is just an exercise.**

Homework

For the caregiver

- **Ask the caregiver to try to implement more active listening at home with his or her child in the next week. Ask the caregiver to observe any differences in the way his or her child interacts when using these skills.**

Bottom-Line Behaviors: When Kids Use It, Diffuse It

GOAL **To help caregivers to understand why responding to a verbally acting-out child with a calm, firm voice works better than raising his or her voice.**

EXERCISE

What you do

- Ask the caregiver to engage in a role-playing exercise with you.
- Instruct the caregiver to stand face-to-face with you. Instruct the caregiver to play the child while you play the caregiver.
- Instruct the caregiver to act out a situation in which their child is angry about not getting her way and is hollering at you. Instruct the caregiver to continue arguing until you tell him or her to stop.
- When the caregiver (playing the child) begins, start to argue back, becoming louder with the "child." Engage in a power struggle.
- End it after a few minutes and ask the caregiver how she felt. Ask if the caregiver noticed whether she became louder as the power struggle evolved.
- Instruct the caregiver to once again play the child and do the same exact thing. This time, however, start with a normal tone of voice and let it become softer. Notice if the caregiver also softens.
- End it after a few minutes and ask the caregiver how she felt that time. Ask if the caregiver noticed whether she became softer your tone of voice softened.
- Explain that by raising her tone of voice, that the child will raise his or her tone of voice to equal or exceed the caregiver, but that by softening her tone of voice the child will likely start to lower his voice to match the caregiver. Also, the child will have to become softer in order to understand what the caregiver is trying to say.

Homework

For the caregiver

- Ask the caregiver to practice implementing the de-escalation technique of responding to their child's verbally acting-out behavior in a calm, firm voice. Ask the caregiver to keep a record of each incident that occurs throughout the week.

Actively Ignoring Mild Negative Behavior

GOAL **To teach caregivers how to actively ignore mild negative behaviors.**

EXERCISE

What you need

- The "Actively Ignore It" handout for caregivers

What you Do

- Go over the ***Actively Ignore It*** handout with the caregiver, discussing the rationale for actively ignoring mild negative behavior.
- Engage the caregiver in a role-play in which he is the caregiver and you are the child.
- As the child, switch between engaging in mild negative behavior and behavior that is more serious or dangerous.
- Ask the caregiver to respond appropriately to these behaviors (i.e., ignoring the mild negative behavior and addressing the more serious or dangerous behavior.

Homework

For the caregiver

- Ask the caregiver to make a list of the mild negative behaviors he sees his child engaging in. Ask the caregiver to practice active ignoring and to document when he actively ignored mild negative behavior and how it worked.

Actively Ignore It

A Handout for Caregivers

Attention is very rewarding to your child - even when it is negative. For example, if your child whines and you respond by yelling, your child has gained your negative attention and is likely to repeat that behavior. Yelling may seem effective because it stops children from misbehaving for the moment, but it does not stop children from repeating the behavior in the future.

Think about it. You probably yell at or lecture your child about the same problem behaviors over and over again. This suggests that the yelling is not working.

To decrease your child's negative behaviors you can learn to actively ignore the mild negative behaviors (e.g., whining), while praising the positive behaviors you would like to see instead (e.g., asking nicely or accepting a 'no' response).

Active ignoring can be very effective when responding to mild annoying behavior problems such as whining, tantruming, complaining, etc. However, active ignoring should not be used with behaviors that may cause harm to the child or someone else if they continue or increase (e.g., hitting).

What are some mild negative behaviors that your child displays that you can actively ignore?

_____

_____

_____

_____

_____

_____

_____

_____

Adapted from Deblinger and Stauffer (2004) UMDNJ-SOM CARES Institute

Positive and Negative Consequences

GOAL **To help the caregiver use positive and negative consequences to modify their child's behavior.**

EXERCISE

What you need

- **The "Using Positive & Negative Consequences" handout for caregivers**

What you Do

- **Engage the caregiver in a discussion about the differences between positive and negative consequences.**
- **Ask which type of consequence she uses more often with her child.**
- **Brainstorm with the caregiver and generate a list of positive and negative consequences that would be appropriate for her child.**

Homework

For the caregiver

- **Ask the caregiver to refer to the list of positive and negative consequences she generated during the session when managing her child's behavior and to record: (1) The behavior; (2) The consequence, and (3) The result.**

Using Positive & Negative Consequences

A Handout for Caregivers

Using Positive Consequences:

To encourage positive or cooperative behavior describe a positive consequence that will follow the positive behavior.

Examples:

- After we finish clearing off the table, you can watch the T.V. show you wanted.
- If you do your homework now, we'll have time to go for ice-cream later.

Using Negative Consequences:

When your child engages in a problem behavior that cannot be actively ignored, you may use a negative consequence to discourage the problem behavior. These are most successful when they are: (1) In your control; (2) Important to your child; and (3) Short in duration.

Examples:

- If you choose to continue to pick on your little brother, you will not be allowed to watch T.V. for one hour.
- If you choose not to complete your homework, you will lose one hour of playing outside with your friend after school tomorrow.

Natural negative consequences are negative consequences which occur naturally in a situation. Allowing your child to suffer natural negative consequences can often go a long way to resolving a behavior problem.

Examples:

- Not helping with the laundry ... not having a special shirt to wear.
- Refusing to eat dinner ... feeling hungry

General guidelines:

1. Encourage positive or cooperative behavior with praise and/or reminders of the positive consequences that will follow the cooperative behavior.
2. Eliminate reinforcing consequences your child may be receiving for problem behaviors (e.g., yelling, lecturing, getting his/her way, etc.).
3. Identify logical negative consequences that are in your control, that are important to your child, and that are short in duration.
4. Use a calm but firm tone of voice when making an if/then statement.

Adapted from Deblinger and Stauffer (2004) UMDNJ-SOM CARES Institute

Chart Child Progress

GOAL **To help the caregiver better understand their child's progress through treatment**.

EXERCISE

What you need

- **The "Child Progress Chart" handout**

What you do

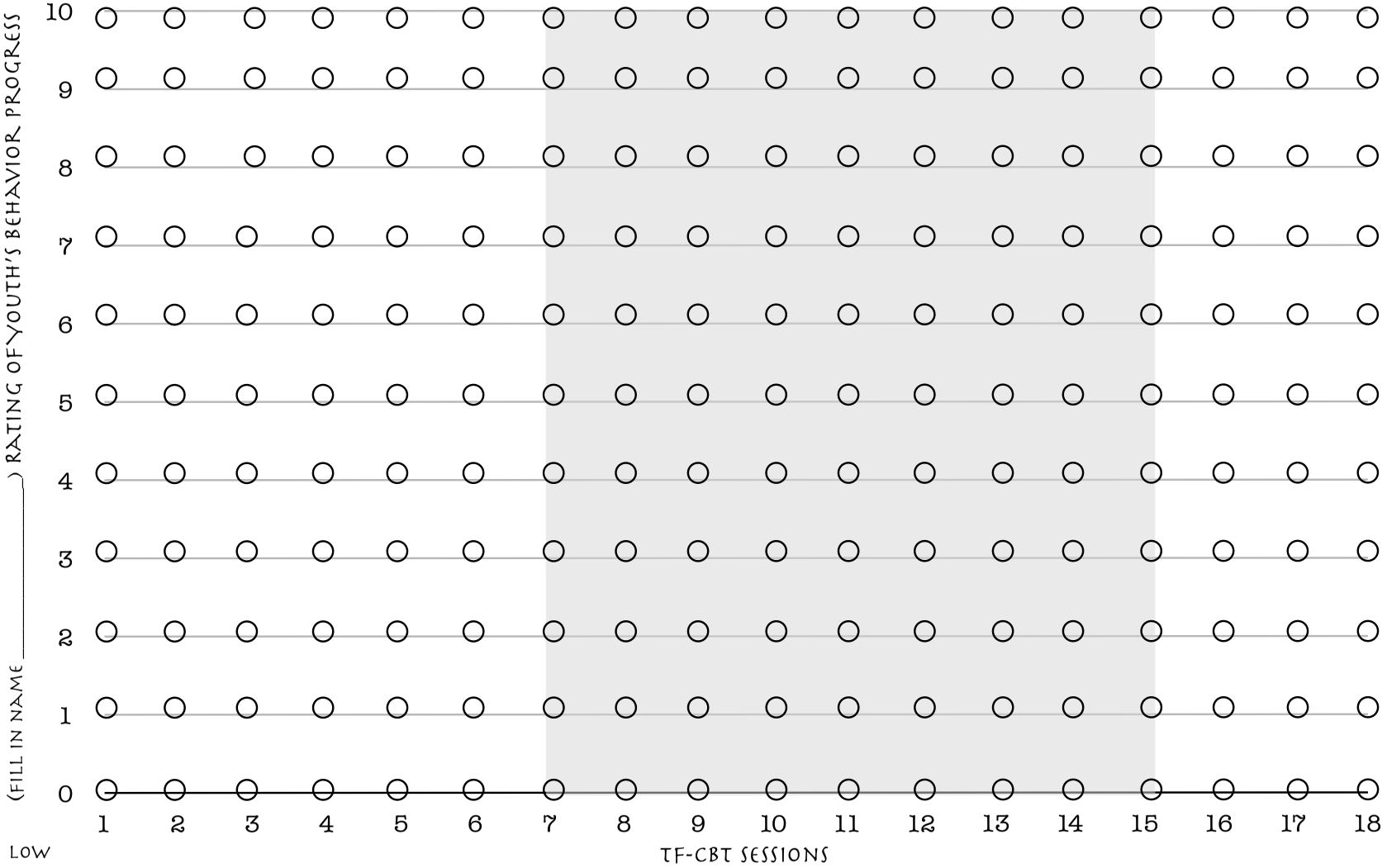
- **Use as many copies of the Child Progress Chart as needed to track each behavior or symptom the caregiver observes at home and is most concerned about.**
- **You might have both the caregiver and child chart the child's progress.**
- **At each session have the caregiver (and child) fill in their rating by coloring in the circle that corresponds to the session number and their 0 to 10 rating.**
- **The shaded area includes sessions that might show more fluctuation in behavior and symptom expression due to more intensive work on the trauma narrative during that time.**

Homework

For the caregiver

- **Ask the caregiver and child to pay particular attention to the child's behaviors/ symptoms during the week. You might suggest that they keep track of behaviors/ symptoms during the week using a daily diary in order to improve the validity of their weekly ratings.**

PROGRESS CHART (FILL IN WHAT IS BEING RATED? _____)



Coffee Card "Score-Keeper" Technique

GOAL **To help the child to monitor and adjust his behavior using a reward system**.

EXERCISE

What you need

- **Score-Keeper Template**
- **Exchange Sheet**

What you do

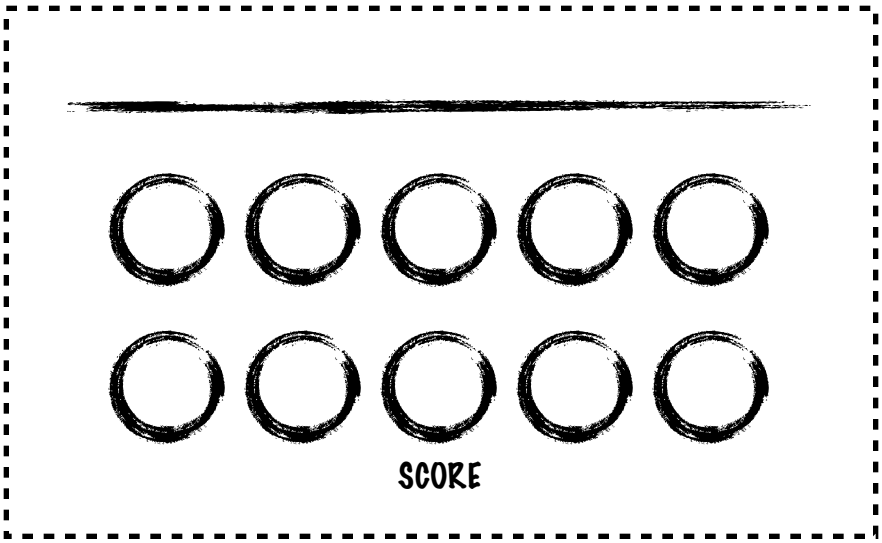
- **Older children often scoff at point systems and star charts, however, even adults use coffee cards (e.g., buy 6 coffees and get your 7th free).**
- **Use the included template to create a number of coffee cards or 'score-keepers' for the child.**
- **Work with the child and the caregiver to create a list of score-worthy behavior (e.g., completing his homework). Also, create a list of rewards on the Exchange Sheet such that the child can turn in points in exchange for a reward (e.g., 5 points for extra time staying up, 10 points to rent a video game, 20 points to eat out at a favorite restaurant.**
- **The reward list should include things that will motivate him to participate.**
- **Instruct the child to keep his score-keeper in his wallet or pocket. Tell him that each time he finds himself doing one of the desirable behaviors on the list that he can ask his caregiver to increase his score by initialing one of the circles.**
- **Instruct the caregiver to praise the child for exhibiting the desirable behavior.**
- **Tell that child that he is solely responsible for his card and that if he loses it, he loses the points he already earned.**

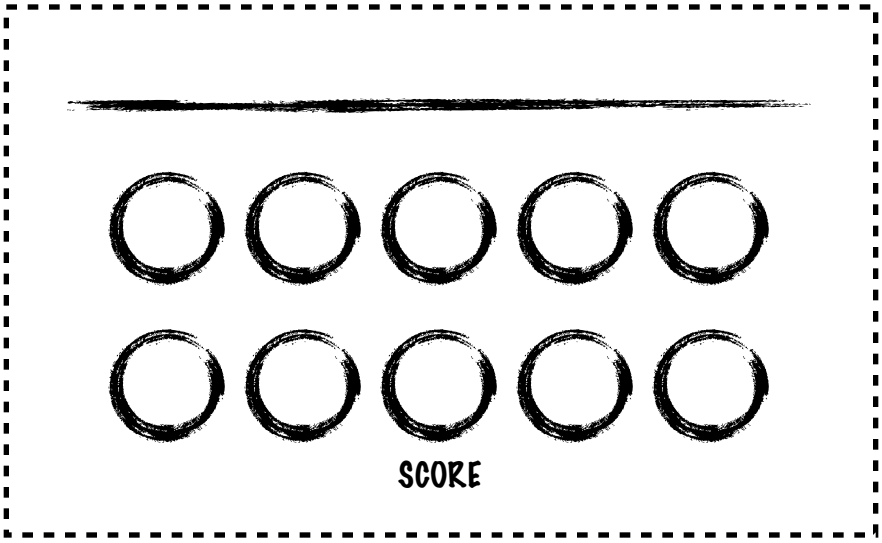
Homework

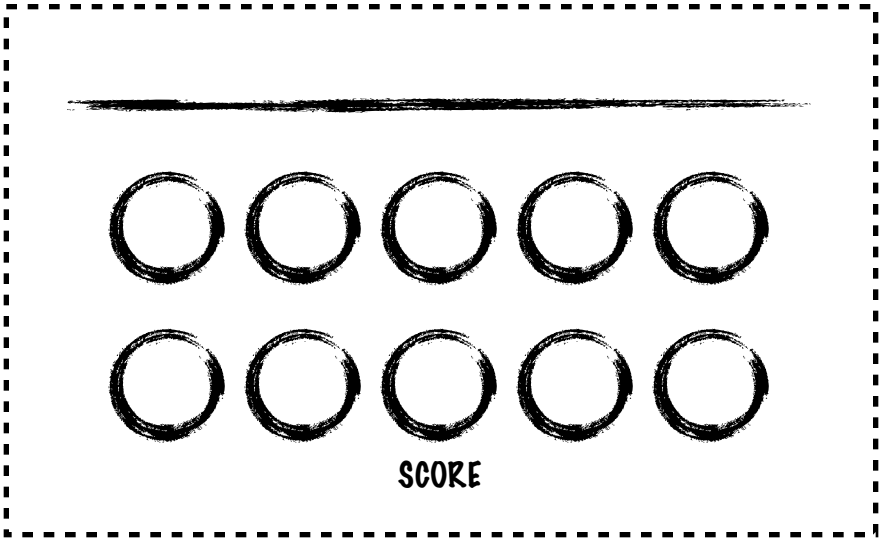
For the caregiver

- **Ask the caregiver to display the Exchange Sheet in a place where the child will see it frequently.**

SCORE KEEPER TEMPLATE







Exchange Sheet

5 Points _____

10 Points _____

15 Points _____

20 Points _____

25 Points _____

30 Points _____

35 Points _____

40 Points _____

House Rules

GOAL **To help the caregiver to set clear expectations for behavior for themselves and their children to follow**.

EXERCISE

What you need

- **The "House Rules" Worksheet**

What you do

- **Explain to caregivers that by establishing a set of rules that everyone in the house is supposed to follow will reinforce the desired behavior in the child.**
- **Explain that children model behaviors from others.**
- **Explain that by establishing a set of rules:**
  - **rules cannot be forgotten;**
  - **rules cannot be debated;**
  - **rules are not open to interpretation.**
- **Explain that rules should be established for things the caregiver finds himself repeating to the child more than once.**
- **No more than five house rules should be posted, and even fewer with younger children.**
- **Rules should be very specific in wording.**
- **Everyone in the household should agree to follow the rules.**
- **Explain to the caregiver that he may have to establish set consequences for breaking specific house rules. If consequences are established then they should be applied each time the rule is broken.**

Homework

For the caregiver

- **Ask the caregiver to come up with a list of common difficulties that occur in his household. Using the House Rules worksheet, ask him to establish a set of house rules that address these difficulties. Next, ask him to negotiate a set of house rules with the family. Finally, have him establish clear consequences for breaking house rules.**

House Rules

1. _____

consequence: _____

2. _____

consequence: _____

3. _____

consequence: _____

4. _____

consequence: _____

5. _____

consequence: _____

Keep up the good work!

5-Minute Work Chore

GOAL **To teach the caregiver an effective form of discipline when the child refuses to comply with a request**.

EXERCISE

What you need

- **The "5-Minute Work Chore" Worksheet**

What you do

- **Ask the caregiver to make a list of jobs/chores around the house that would take about five minutes to complete. They should include chores that the child does not like to do or is not routinely expected to perform.**
- **Explain to the caregiver the following key guidelines when using this form of discipline:**
    1. **When making a request try not to disrupt things like homework time or planned television time.**
    2. **Make it clear to the child that not complying will mean he will have to do a work chore.**
    3. **If the child refuses to do what is asked, do not argue or lecture, but simply assign the work chore.**
    4. **Each time you are about to make a request, have two work chores in mind that you could use.**
    5. **If your child fails to complete the chores use no more than two work chores before withdrawing a privilege.**
    6. **Stay out of the way while your child is doing the chore.**
    7. **Remain calm and neutral.**

Homework

For the caregiver

- **Ask the caregiver to practice making requests and implementing the 5-Minute Work Chore when necessary.**

The 5-Minute Work Chore

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

What is Time-Out

GOAL **To teach the caregiver how to effectively use time-out**.

EXERCISE

What you need

- **The "Time-Out Guidelines" handout**

What you do

- **Discuss with the caregiver her experiences using time-out.**
- **Have the caregiver generate one problem behavior that she cannot actively ignore or that she would like her child to stop.**
- **Talk with the caregiver about any reinforcing consequences (e.g., yelling, lectures, attention, etc.) her child may be receiving for that problem behavior.**
- **Discuss the benefits of sticking to a consistent routine and following the guidelines recommended on the handout.**

Homework

For the caregiver

- **Ask the caregiver to implement time-out routine at home as indicated on the handout.**

Time Out Guidelines

1. Be positive when explaining how time out works. Explain to your child that it is intended to help her to remember a particular rule.
2. Role-play or use dolls to show your child how time out works.
3. Start by using time out for one problem behavior or one important rule.
4. Choose a boring place, free of distractions, for time out.
5. Every time the chosen problem behavior occurs - call time out in a calm, unemotional manner.
6. Do not yell or offer additional comments when giving a time out.
7. Set a timer for 5-10 minutes depending on the child's age. Use shorter intervals for younger or overactive children.
8. Actively ignore and withdraw all privileges from the child until he goes to and completes time out. When necessary, repeat a simple phrase like, "not until you do your time out."

Adapted from Deblinger and Stauffer (2004) UMDNJ-SOM CARES Institute

Modeling Good Anger Management

Caregiver Information Sheet

Anger is a natural emotion, one that we all have felt. Very young children are likely to express anger physically - by yelling, hitting or pushing, or even biting. This is an instinctive response. But if a child continues to respond to anger with aggression, he may have trouble in relationships with friends, family members and teachers, and may actually create danger for himself.

Preschool-aged children are learning how to identify anger and other emotions in themselves and others, and to link names to them. They become able to tell you when they are sad, angry, happy, disappointed, or confused. They will need help throughout childhood to develop a larger vocabulary of feelings, and learn to express their negative feelings with words.

How you respond to your child's emotions will greatly affect how well she learns to cope. When you model good anger management skills yourself, you are providing a strong foundation for your child to learn how to cope with stress.

Here are some anger management strategies that may help you and your child navigate stressful situations with greater ease:

- Practice deep breathing. Take each breath from down in your belly, keeping it slow and even as you breathe in and out for 30 seconds or so.
- Create a word or phrase to repeat in your mind as you take time-out for a few deep breaths: “all is well,” or “take it easy,” for example.
- Give yourself a moment to look carefully at what has triggered your anger. Ask yourself whether it really deserves an angry response. Was it an accident? Did you misunderstand what was said? Find out before you react.
- Create a time-out signal that must be respected by everyone in the family whenever anyone uses it.
- Take time-out when you are under stress or frustrated. Give yourself 15 minutes when no one is allowed to talk to you. Use that time to practice a favorite method of relaxation. Angry explosions are sometimes the result of keeping things in until they must find a way out. Defuse the feeling before it reaches that state.
- Talk out your angry feelings with someone you trust.
- Try to see yourself and your situation with a sense of humor. Picture yourself throwing a pie in the face of your annoying co-worker, or waving a magic wand and summoning your fairy godmother to tell you what to do with your over-tired child.
- Sit down with your child with crayons and paper. Have each of you draw a picture of what your anger looks like, then talk about it.
- Try to get enough sleep each day, and to eat a diet rich in fruits, vegetables, and grains, and low in sugar.

Notes

Notes

Notes

Notes

Relaxation

The Nervous System

GOALS **To help the child to recognize how stress affects his or her body and to identify ways to effectively manage stress.**

EXERCISE

What you need

- The Brain & The Body Work Together Worksheet

What you do

- Use the worksheet to introduce the nervous system and how the brain and body work together.
- Explain how the brain responds to stress and how it communicates this to the rest of the body.
- Talk about ways in which the body is affected by stress.
- Discuss ways in which the child might focus on his or her body in order to manage stress effectively.

The brain and Body Work Together

The Nervous System

The Brain

The Spinal Cord

Nerves

Stress affects the whole body. When something is wrong the brain activates an alarm system. The alarm system alerts the rest of the body.

What kinds of things happen to your body when you are stressed?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

One way to manage stress and to start to relax is to calm your body down. You can do this by slowing down your breathing, relaxing your muscles, closing your eyes, going for a walk or a run, or finding a comfortable place to sit.

What can you do when you are stressed?

_____
_____
_____
_____
_____
_____
_____
_____

Deep Breathing

GOAL **To teach the child to use deep breathing as a relaxation technique**.

EXERCISE

What you need

- **The “Deep Breathing” worksheet**
- **The “Practice Deep Breathing” worksheet**

What you do

- **This exercise should be used in conjunction with the deep breathing section of the Trauma-Focused CBT handbook.**
- **Using the pictorial diagram, teach the child to inhale slowly (about 3 seconds) while feeling his or her stomach rise.**
- **Teach the child the difference between inhalations that cause the chest to rise versus inhalation that causes the stomach to rise.**
- **Instruct the child to exhale slowly (about 3 seconds), pushing all of the air out of his or her lungs and feeling the stomach fall.**
- **Instructing the child to make a hissing sound when exhaling might help slow his or her exhalation.**
- **Have the child engage in deep breathing for about 3 to 5 minutes.**
- **You might use a timer. Sand timers are a good way to measure the time period.**
- **In a conjoint session, you might have the child teach his or her caregiver how to engage in deep breathing.**

Homework

For the child

- **Ask the child to practice deep breathing outside of therapy. Tell the child that deep breathing is a convenient technique because it can be done anywhere.**

For the caregiver

- **Ask the caregiver to sit down with the child throughout the week to practice deep breathing together.**

Deep Breathing Worksheet

1 Find a comfortable spot to sit and relax.

2 Close your eyes and place your hand on your stomach.

3 Slowly breathe in and feel your stomach rise. Count to 3.

4 Slowly breathe out and feel your stomach fall. Count to 3 and repeat.

Practice Deep Breathing

Before

Right now I am feeling _____

After

After deep breathing I am feeling _____

While you were practicing, did anything make it hard for you to relax? _____

Is there anything different you can do next time to help you to relax? _____

Relaxation on the Go: For Caregivers

GOAL **To explore the caregiver's current stress management habits and to teach the caregiver the benefits of relaxation.**

EXERCISE

What you need

- The "Relaxation on the Go" worksheet
- The "Relaxation on the Go" handout

What you do...

- This exercise should be used in conjunction with techniques described in the stress management section of the Trauma-Focused CBT handbook.
- Complete the worksheet with the caregiver.
- Use the worksheet to explore ways in which the caregiver currently manages his or her stress.
- Also, use the worksheet to generate conversation regarding the benefits of relaxation.
- Explain to the caregiver that the way in which he or she manages stress will influence how his or her child manages stress.
- Explain to the caregiver that using relaxation techniques to manage stress will model good stress management skills.
- Give the Relaxation on the Go Handout to the caregiver so that he or she can review it at home.
- Ask the caregiver to make relaxation a priority and a routine practice in the household.

Relaxation on the Go Worksheet: 10 Questions

1. **How do you handle hassles and major stressors?**

2. **What are some examples of stressors in your life?**

3. **What kinds of feelings or emotions do you experience in response to these stressors?**

4. **What kinds of thoughts do you have in response to these stressors?**

5. **What does your body do in response to these stressors?**

6. **What are some positive or healthy things you do to try to manage this stress?**

7. **What are some negative or unhealthy things you do to try to manage this stress?**

8. **What kinds of resources do you have available to help manage daily stress?**

9. **How does your social support network help you to manage stress effectively?**

10. **How do you think the ways in which you manage your stress influence your child and the people around you?**

Relaxation on the Go

A Handout for Caregivers

Even though we know that taking time to relax is an important part of keeping ourselves healthy, we don't always have time to take a long walk or to soak in a bubble bath. The realities of our lives can make it difficult to engage in activities like these, but there are many other ways to relieve stress and bring yourself back to center, even when you don't have much time. Here are a few ideas:

Deep Breathing

Begin by breathing in slowly through your nose, drawing the breath all the way down into your belly (actually, the lower parts of your lungs, which are very big) before letting it flow upward to fill the top part of your lungs. As soon as you complete your in-breath, breathe out slowly through either your nose or your mouth. Repeat this three times. Remember to do full, deep, slow breaths. After just three, you should feel noticeably different.

Your Personal Calm Spot

Think of a place where you have felt calm, safe, and very relaxed. For some people, this may be on the beach, watching and listening to the ocean. For others, it may be at a grandmother's house, sitting and talking while she gets dinner ready. Or it could even just be sitting under a favorite tree. When you have decided upon your own personal calm spot, enrich your memory of it by remembering the sounds, the smells, the tastes, and the feelings that were a part of that place. Let yourself remain there for a few minutes, long enough to imprint the experience of being there on your mind. Now, whenever you need to, you can take yourself into your personal calm spot for a few minutes of relaxation.

Slow(er) Walking

Even if you are in a hurry, slowing down the pace of your walking will make little difference in the time it takes to get where you're going. Take a moment to notice how you are moving. Are your muscles all tensed up for speed? Are you leaning forward, reaching for your goal before you arrive? Slow down. Straighten up. Let your body feel as if it is suspended from an invisible string that reaches from the top of your head far up into the sky. Begin to measure each step so that you are taking exactly the same time to move each foot forward… slowly, consciously, and with pleasure. Now breathe!

Remembering to Relax

GOAL **To encourage the child and caregiver to practice relaxation techniques outside of therapy.**

EXERCISE

What you need

- **The "Remembering to Relax" worksheet**

What you do

- **Discuss with the child why it is important to practice relaxation outside of therapy sessions.**
- **Explain that most people are not very good at relaxing at first, but become better at it with practice.**
- **Introduce the Remembering to Relax Worksheet.**
- **Explain that the worksheet will help the child to remember to practice relaxation at home.**
- **Use one worksheet for each week.**
- **Have the child put his or her name and the date on the worksheet.**
- **Encourage the child to decorate it.**
- **Help the child to decide upon a certain amount of time to practice relaxation each day and write that amount of time on each of the tags at the bottom of the worksheet.**
- **Tell the child to hang the worksheet on the refrigerator or someplace where he or she will see it every day.**
- **Tell the child to tear off the tag that corresponds to which day of the week and it is and to spend the agreed upon amount of time practicing relaxation techniques at home.**
- **You might create a set of worksheets for the caregiver to hang on the refrigerator as well.**

Homework

For the child

- **Ask the child to save the tags from the worksheet in an envelope or jar so he or she can keep track of his or her accomplishments.**

For the caregiver

- **Ask the caregiver to model for the child by hanging his or her own worksheet in a visible place and making relaxation a daily routine.**

Remember to Relax...

Your name

Draw or paste picture here.

month/day/year to month/day/year

MONDAY
Relax for ___ Minutes

TUESDAY
Relax for ___ Minutes

WEDNESDAY
Relax for ___ Minutes

THURSDAY
Relax for ___ Minutes

FRIDAY
Relax for ___ Minutes

SATURDAY
Relax for ___ Minutes

SUNDAY
Relax for ___ Minutes

Customized Relaxation Recording

GOAL **To encourage the child to practice relaxation techniques at home.**

EXERCISE

What you need

- The "Relaxation Recording" worksheet
- Audio recording device
- Audio recording computer software (optional)

What you do

- Discuss with the child why it is important to practice relaxation outside of therapy sessions.
- Tell the child that it can be easier to relax in the presence of relaxing music and verbal instructions.
- Introduce the Relaxation Recording Worksheet.
- Explain that the child will be creating his or her own relaxation recording track. Prior to the session you may want to ask the child to bring in music that he or she finds relaxing. Alternatively, you might have some available for the child to select from.
- Use the worksheet to come up with an outline for the recording.
- First, have the child choose the relaxation technique he or she has learned and wants to include in the recording.
- Then, break the technique down into verbal instructions and have the child create a script that he or she will read during the recording.

Homework

For the child

- Ask the child to practice the relaxation technique by playing the recording at home and to encourage his or her caregiver to listen to it.

For the caregiver

- Ask the caregiver to listen to the child's recording and to practice the relaxation technique with the child.

My Relaxation Recording

What is the title of your recording? _____

Which relaxation technique will you use? _____

Are you going to add music to it? _____

Relaxation Technique Script

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Introducing Mindfulness: Do Not Disturb

GOAL **To help the child better understand the concept of mindfulness and the ability to enhance one's focus in order to reduce distressing and distracting thoughts.**

EXERCISE

What you need

- Model of the brain or anything that depicts the brain (e.g., cap, ball)
- Small and large sticky notes

What you do

- Discuss with the child what kinds of thoughts one has when feeling stressed out or anxious and how it can be difficult to concentrate on a task when one has a number of distressing thoughts and worries on one's mind.
- Using the small sticky notes, ask the child what kinds of thought he or she has when feeling stressed or anxious and write each down on a sticky note.
- Stick each note onto your model of the brain so that the sticky notes take up nearly the entire surface.
- When the child has generated a number of thoughts, ask the child whether he or she thinks the brain can handle all of these thoughts at once. Discuss how these thoughts can overwhelm and further stress the brain.
- Discuss the notion of mindfulness and explain how it is like becoming good at focusing on one thing so that other thoughts and worries do not try to steal the brain's attention. Start taking the sticky notes off of the brain and put them in a pile.
- Take the larger sticky note or a piece of paper and write "Do Not Disturb" on it. Stick it on the brain so that it takes up a good portion of the surface. Explain how mindfulness and meditation is like putting up a "Do Not Disturb" sign on the brain as a way to enhance focus and induce relaxation.

Homework

For the child

- Ask the child to take some time during the week to practice focusing on one thing (e.g., a word, image, breathing). Explain that people are not generally good at this in the beginning but improve with practice.

For the caregiver

- Ask the caregiver to do the same as the child and talk about the benefits of practicing mindfulness in everyday life. Also explain that by taking time to practice mindfulness and relaxation, the caregiver is providing a good model for the child.

Mindfulness Skills Training

GOAL **To help the child and caregiver begin to practice mindfulness.**

EXERCISE

What you need

- **The "Mindfulness Skills Training" worksheet**

What you do

- **Teach the child the concept of mindfulness and how it is helpful.**
- **Explain that mindfulness is being aware of the present moment - observing what is going on both inside and outside of the body.**
- **When practicing mindfulness, he or she might observe all kinds of things including: (a) sights, smells, and sounds happening in the environment, (b) thoughts and memories, (c) bodily sensations, and (d) feelings.**
- **Explain that the child should observe these things but should not evaluate them. In other words, the child should not become fixated on any particular thought or memory and should not try to solve any problems. The child should not push away thoughts and feelings, but should not hold onto them.**
- **Use the instructions on the Mindfulness Skills Worksheet to practice mindfulness during the session.**
- **Use may also use the Mindfulness Skills Worksheet to introduce mindfulness to the caregiver.**

Homework

For the child and caregiver

- **Ask the child and caregiver to set aside about ten minutes during the week to practice mindfulness. Ask them to follow the instructions on the Mindfulness Skills Worksheet.**

Mindfulness Skills

Find a place where you will be comfortable for about 10 minutes.

Close your eyes and start to relax using deep breathing.

As you begin to relax, notice the sounds and smells that are happening around you. Notice what your body is doing. How does your stomach feel? How does your skin feel? How do your toes feel? What are your hands touching?

Notice your thoughts and feelings. Watch them come and go like clouds in the sky. Don’t push them away. Don’t hold onto them. Let them come and go.

As you notice your feelings, give them names. You may have many feelings during this exercise.

Realize your thoughts are only thoughts, not facts. For example, thinking that you or someone else is dumb or stupid does not mean that you actually are. It is only a thought.

Do not judge or criticize yourself. Focus on being in the present moment and observing you and your surroundings.

Remember to continue deep breathing.

After about 10 minutes, slowly open your eyes and look around.

How did it go?

Notes

Notes

Notes

Notes

Notes

Affective Modulation

Personalized Emotion Chart

GOAL To help the child express and manage feelings more effectively.

EXERCISE

What you need

- The "Personalized Emotion Chart" worksheet
- Digital camera
- Photo editing computer software

What you do

- Describe what a typical emotion chart looks like by drawing one or using an existing chart.
- Explain that you are going to help the child create his or her own emotion chart, using his or her own facial expressions.
- Ask the child to make a list of as many different emotion words as possible.
- Using a digital camera, take pictures as the child makes a facial expression for each emotion word on his or her list.
- Upload the pictures to a photo editing computer software program.
- You may need to clean up and size the photos.
- Copy and paste the photos into a word processing document.
- Help the child to arrange the photos and label them with the matching emotion words.

Homework

For the child

- You may find it necessary to obtain caregivers' written permission to take photographs of their children, specifying that you will use pictures only in the context of the child's therapy.
- Ask the child to hang his or her emotion chart in a noticeable place (e.g., refrigerator) and to think about when during the week he or she experiences each emotion word/ expression.
- You might also ask the child to show the emotion expressions to his or her caregiver with the emotion words covered and then to ask the caregiver to match the child's facial expressions to the correct emotion word.

For the caregiver

- You might ask the caregiver to create his or her own list of personal experiences to match each emotion word on the child's chart.

Wheel of Feelings

GOAL **To help the child better understand and express his or her feelings.**

EXERCISE

What you need

- Wheel of Feelings game board and wheel
- Push pin
- Cork board

What you do

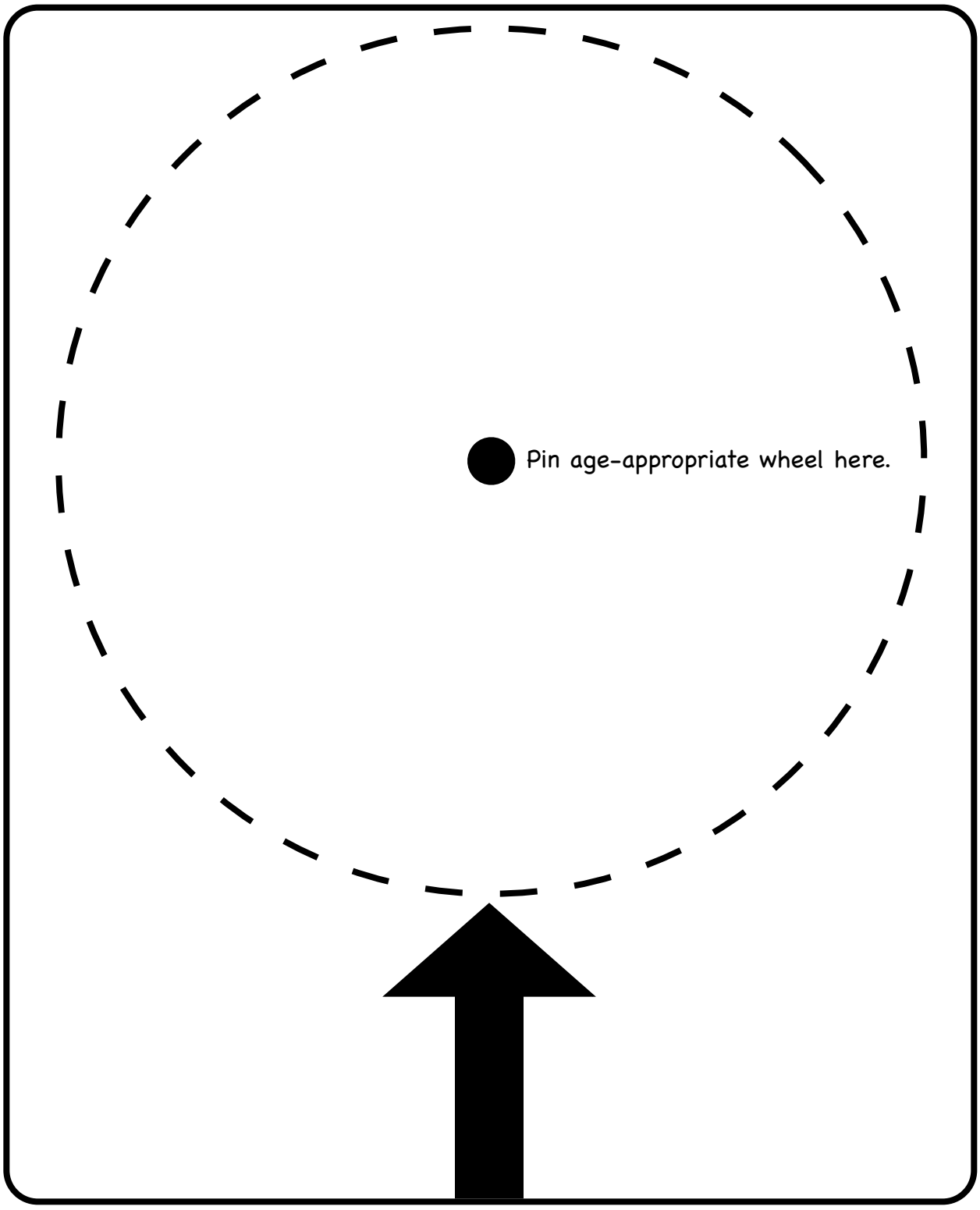
- You must construct the Wheel of Feelings.
- Cut out the circles.
- Choose the Wheel most appropriate for the child you are working with.
- Pin the wheel and the board onto the cork board.
- Make sure the wheel spins.
- Ask the child to play a game and introduce the Wheel of Feelings.
- You start first to model for the child how to play the game.
- Spin the wheel.
- Describe a time that you felt the emotion that the spinner lands on.
- Take turns spinning the wheel.
- You may want to incorporate points. To do so simply write in a point value for each feeling word.

Homework

For the child and caregiver

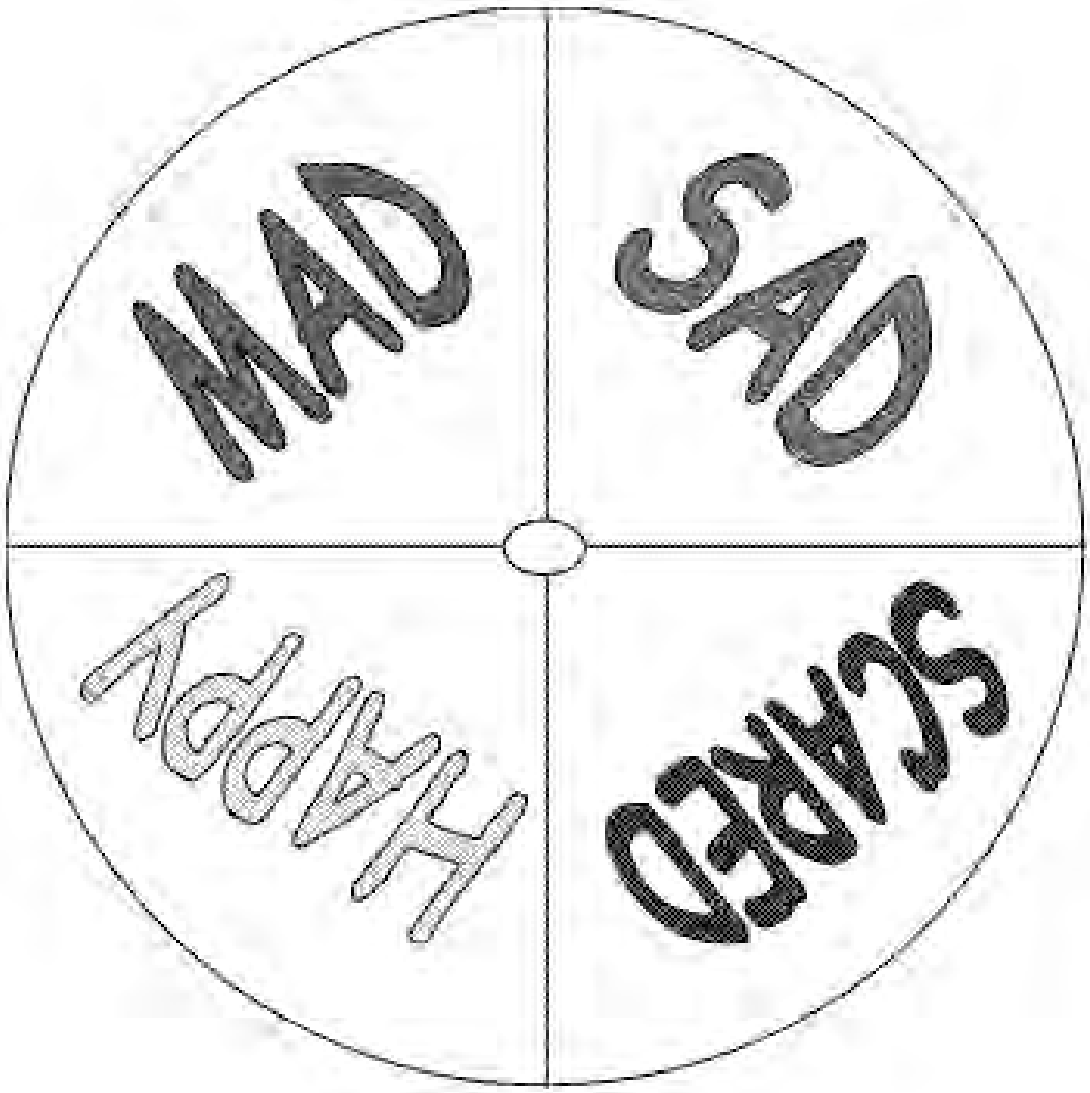
- Encourage the child and the caregiver to play this game at home and to invite other family members to play.

Wheel of Feelings Game Board



Wheel of Feelings

Easy



Wheel of Feelings

Challenging

Wheel of Feelings
Most Challenging

What am I Feeling? A Charades Game

GOAL To help the child to better identify emotions.

EXERCISE

What you need

- Sticky notes

What you do

- Ask the child to participate in a game.
- The game involves guessing the other player's mood based on his or her expression and behavior.
- On a player's turn, he or she writes an emotion word on a sticky note and posts it on the other player's back.
- Without using words, the player then uses expressional gestures and behavior to try to communicate to the other player what emotion word he or she wrote on the sticky note.
- The objective of the game is to work together to reach a set number of points (e.g., 100) within a fifteen minute period (or whatever you decide upon).
- Thus, every time a player correctly guesses the other player's chosen emotion word, the team earns a set number of points (e.g., 10).
- If there is an opportunity to have 4 or more players, then you might play team A against team B.
- You might allow enough time at the end for the child to play a round with his or her caregiver.

Homework

For the child and caregiver

- Encourage the child and the caregiver to play this game at home and to invite other family members to play the game.

The Volcano Speaks

GOAL **To help the child learn to modulate anger and express feelings in an appropriate way.**

EXERCISE

What you need

- **Drawing paper**
- **Crayons, colored pencils, or markers**

What you do

- **Ask the child to make a picture of a volcano, or a storm (e.g., thunderstorm, tornado, hurricane) that would show how angry the child was on a particular occasion.**
- **Alternatively, they may draw a picture of an angry monster (e.g., fire-breathing dragon).**
- **Take a measure of how much anger is displayed in the picture: on a scale of 1-10, if the picture is of a passing thunderstorm, it might rate relatively low on the scale. If, on the other hand, it shows a volcano erupting and destroying a town, that might rate at the top of the scale.**
- **Tell the child to pretend that the volcano can talk about the anger it is feeling. What would it say? Prompt a full explanation (e.g., What else would the storm say about how angry it is?).**
- **Ask the child to pretend that the volcano or storm noticed it was starting to get angry at an earlier point (e.g., point to a lower spot on the volcano). What do you think it could do to calm down? You may introduce words for degrees of anger such as annoyed or irritated.**
- **If the child is unable to think of coping strategies, offer a menu of suggestions for the child to select from (e.g., could it take a time-out to think things over? Could it take three deep breaths and try to relax? Could it turn to a friend for support?).**
- **If you have time, ask the child to draw a new picture of the angry volcano, storm, or monster as it is calming itself.**

Adapted from child therapy techniques developed by David A Crenshaw, Ph.D., Director, Rhinebeck Child and Family Center, LLC.

Using Heartfelt Feelings Coloring Cards©

GOAL **To help the child identify and express feelings related to the key figures in his life and to emphasize a child's strengths.**

EXERCISE

What you need

- **The Heartfelt Feelings Coloring Card Strategies Kit (see resources section), or paper folded to make a greeting card with the outline of a heart on the front.**
- **The group of emotions listed in the clinical manual of the kit, or the child's list of emotions derived from earlier exercises.**
- **Crayons, markers, colored pencils and a pen or pencil.**

What you do

- **Have the child choose several feelings that relate to the person he is thinking about.**
- **Ask him to choose a color to go with each feeling.**
- **Ask the child to color in the heart with a feeling or feelings that he wishes to write about on the inside of the card.**
- **Help the child to write a note to the person he is thinking about on the inside of the card, describing a time when his heart was filled with sadness, worry, shame, or whatever other emotions have been chosen.**
- **Discuss and praise the finished card and decide whether or not to send it to the intended recipient.**
- **The purpose of the exercise is to help the child express feelings and so the card itself most often will not be sent.**
- **To celebrate a newly demonstrated strength, have the caregiver (or if a caregiver is not participating, you may do this) choose a positive emotion like happiness, gratitude, admiration, pride, or respect and select a color to represent that feeling.**
- **Color in the heart on the front of another card with the chosen color.**
- **Write a note on the inside of the card to tell the child what feeling the color represents and what the child did to inspire the writing of the card.**

Using Color to Express Emotion

GOAL **To help the child be able to identify where emotions are felt in the body.**

EXERCISE

What you need

- Drawing paper
- Crayons or markers

What you do

- Help the child to create a list of emotions he has felt during the past week.
- Aim for including positive emotions as well as negative emotions.
- Ask the child to choose a color for each emotion. Mixed emotions (e.g., combination of confusion, disappointment, and anger) might involve a mixture of colors.
- Have the child draw a gingerbread man or person and ask him to add colors to show where he has felt each emotion. Alternatively you can use the drawing on the following page.
- If this activity seems like something the child enjoys you might have him bring in a colored drawing of a gingerbread man or person each session to illustrate how he has felt in the past week.

Feelings Game

GOAL To help enrich the child's feelings vocabulary

EXERCISE

What you need

- Index cards or sticky notes

What you do

- Ask the child to take a few minutes to write down as many feeling words as he or she can.
- Explain that you will be doing the same.
- Praise the child for coming up with any number of words.
- After you and the child have generated a number of words, transfer each word onto an index card or sticky note.
- Tell the child that you will be playing a game.
- Shuffle the cards and lay them out so that the words are face-down and hidden from view.
- You and the child then take turns picking a card and telling about a time when your mood matched the word on the card.
- Explore what was happening at the time. What were you doing? What were you thinking?
- You may want to flip a coin or play "Rock-Paper-Scissors" to see who picks a card next.
- You may also want to increase the difficulty of the game towards the end by picking up two cards instead of one. With two cards the objective would be to think of a time when you felt both of the feelings at the same time (e.g., excited but sad).

Homework

For the child and caregiver

- Ask the child and the caregiver to play the feelings game together at home.
- You might also give the child a handful of index cards so that he or she can find other feeling words to use in the next session.

Notes

Notes

Notes

Notes

Notes

Cognitive Coping

Feel It, Think It, Do It Card Game

GOAL **To help the child to understand the relations between feelings, thoughts, and behaviors.**

EXERCISE

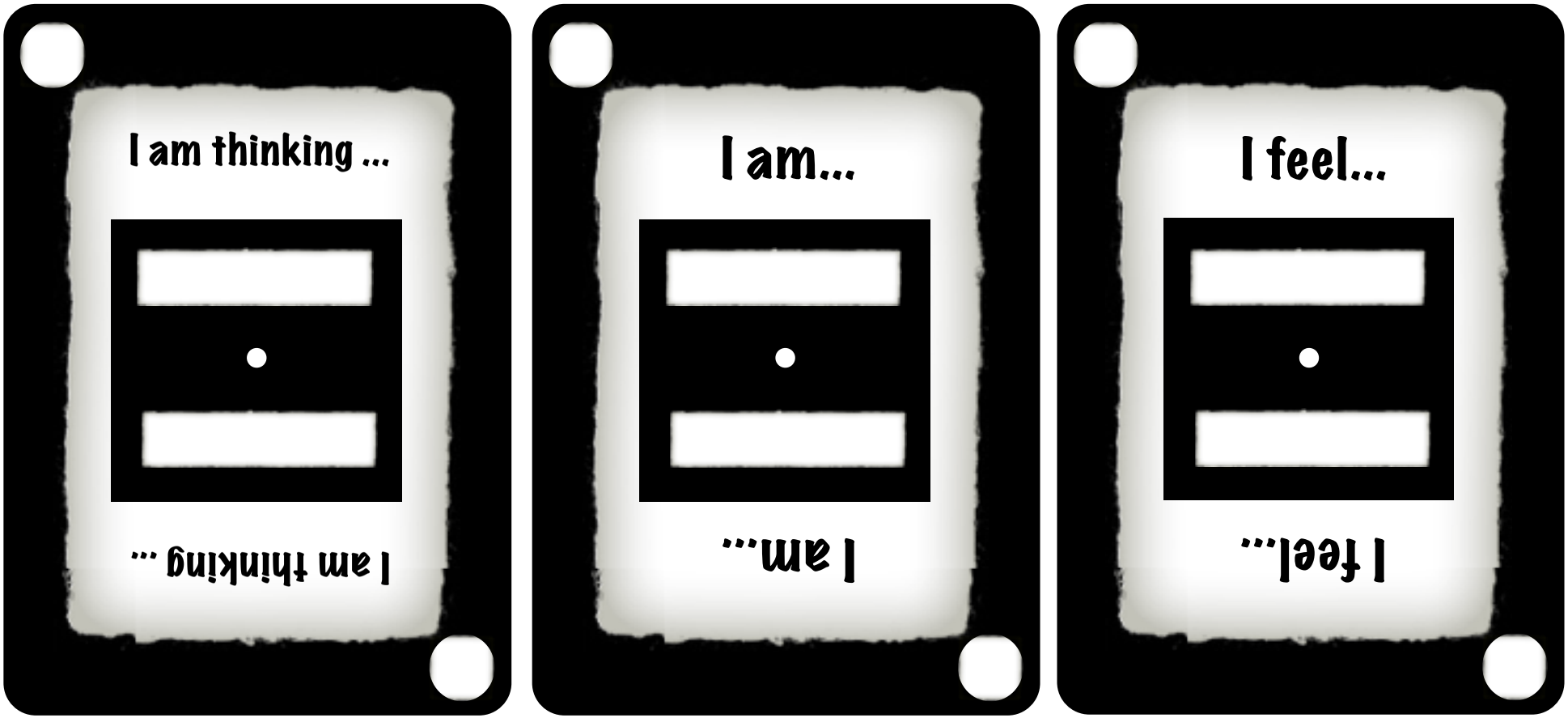
What you need

- The “Feel It, Think It, Do It Template Cards”
- Marker

What you do

- The first step is to make the cards prior to the session.
- Generate 3 sets of cards, each containing 20 cards or more.
- One set will contain positive and negative behaviors (e.g., run 2 miles, throw a rock at a window).
- Another set will contain positive and negative thoughts (e.g., I look good today, I am not good at anything).
- Another set will contain positive and negative emotional expressions (e.g., I feel excited, I feel nervous).
- Use different colors to represent each group (feelings, thoughts, behaviors).
- Choose point values for each of the cards. They could all be the same or they could vary with difficulty.
- At the start of the session ask the child to play a game.
- Shuffle all of the cards and deal each player 7 cards.
- On a player’s turn, he or she must attempt to combine 3 of the cards, one from each of the groups, to tell a story in which a feeling card leads to a behavior card, which leads to a thought card... or any such combination so long as it makes sense.
- For example, a player might have cards that read, “I am excited,” and “I can do this well,” and “build a snowman.” The player might tell a story about someone who feels excited because it is snowing, thinks he is really good at building a snowman, and then builds the snowman. Alternatively, a player might tell a story about someone who thinks she can build a snowman but never has before, builds the snowman, and then is excited because she actually did it well.
- A player places down 3 cards and then tells the story.
- The player receives points for having 3 cards from each category and for telling a story that makes sense.
- After completing a story the player takes 3 more cards from the deck and the turn goes to the next player.
- If a player does not have cards from the 3 categories in hand or cannot think of a story that makes sense, he or she can trade in any number of cards for new cards from the deck. However, the player loses his or her turn.
- You might add other rules as you see fit.

Feel It, Think It, Do It Template Cards



SO MANY POSSIBILITIES

GOAL To help the child discover better, more manageable ways of dealing with stressful situations and/or problems.

EXERCISE

What you need

- The "Possibilities Problem Solving Chart"

What you do

- Ask the child to describe a situation(s) in which he/she had a problem (examples include: school fights, sibling rivalry, yelling at an adult, etc…). Make sure the child not only describes the situation but also how it makes him/her feel.
- After the child describes the situation(s), ask him/her to rank how important it is to come up with a solution (0=doesn't need to be addressed at all, 1=can address it later, 2=need to address it NOW).
  - This may help the child see the importance of some situations and how other situations/problems can be looked past or examined later on.
- Focus on a situation that needs to be addressed immediately and help the child fill in the Possibilities Problem Solving Chart (leave the Results section blank). Fill that section in after the child has tried the "good outcome" possibilities. The child should know that the bad outcome possibilities shouldn't be tried (because they probably already have been and didn't work). If he/she doesn't understand why they shouldn't be attempted, explain it to him/her.

Homework

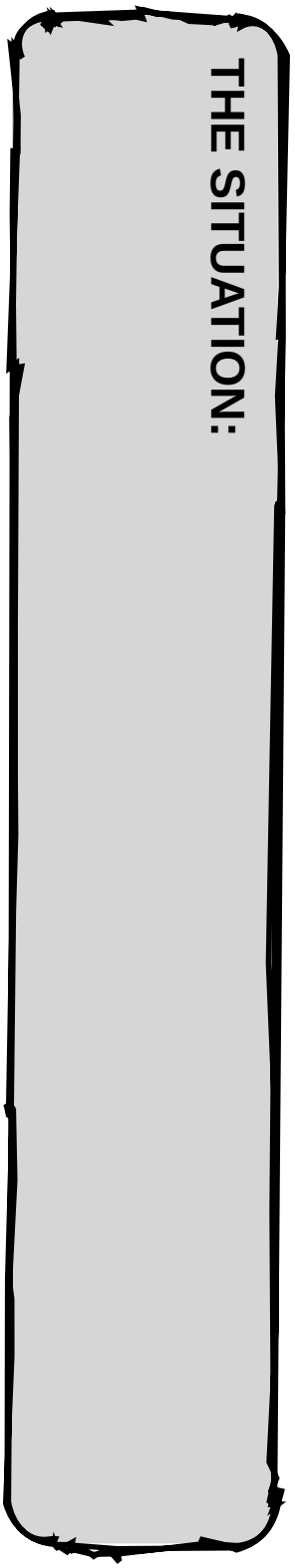
For the Child:

- Have him or her try one or more of the possibilities and report back on its success

Notes:

It may be difficult at first for the child to come up with possible responses and outcomes, so you may have to help. If the child tells you that the "good" outcomes didn't work, reassess the situation and try again.

POSSIBILITIES PROBLEM SOLVING CHART



Possible Responses	Possible Outcomes of Response	Is it a good or bad outcome?	Results

Triangle Chairs Game for Younger Children

GOAL **To help the child to understand the relationships between feelings, thoughts, and behaviors.**

EXERCISE

What you need

- Three chairs
- Construction paper
- Scissors
- Markers

What you do

- Place 3 chairs in the form of a triangle.
- Make 3 labels using 3 different colors that read, “Feeling,” “Thinking,” and “Doing.”
- Place each label on one of the chairs .
- Cut up several paper triangles using the three colors you used for the labels.
- Put all of the paper triangles into a container.
- The game is played by having the child pick a random paper triangle from the container. The color of the triangle the child chooses means he or she should sit in the chair that matches the color.
- The child then chooses what chair he or she wants you to sit in. Once you are sitting, the child generates an emotion word (“feeling” chair), something someone might be thinking (“thinking” chair), or a behavior (“doing” chair) depending on which chair the child is sitting in.
- For example, if the child is in the “feeling” chair he or she might say, “I feel happy.”
- Then, you follow by linking that feeling with either a behavior or a thought depending on which chair you are sitting in.
- For example, if you are sitting in the “thinking” chair you might say, “and I am thinking that I have a lot of friends.”
- Then the child finishes by sitting in the last chair and making the last link.
- For example, if the last chair is the “doing” chair the child might say, “I am swinging on a swing set with my friends.”
- Then it is your turn to choose a triangle, repeating the process.
- You might consider inviting the caregiver to participate in the game. If there are 3 people playing the game, the player whose turn it is decides which chair the other two players sit in.

Do these Thoughts Help or Hinder?

GOAL **To help the child understand the the difference between helpful and unhelpful thoughts.**

EXERCISE

What you need

- **The "Help or Hinder" worksheet**

What you do

- **Discuss the fact that there are a number of different ways to interpret and think about situations and that these might vary depending on one's mood. Give examples.**
- **Explain how thoughts can be helpful or unhelpful.**
- **The worksheet provides a number of scenarios in which the character's unhelpful thought has led to behavior that resulted in worse circumstances.**
- **After each scenario ask the child to generate a thought the character might have had that would have been helpful instead of unhelpful.**
- **Discuss how the character's behavior might have been different given this thought.**
- **Ask the child to think of times in which his or her thoughts led to behavior that worsened the situation.**
- **Ask the child to generate thoughts that might have helped vs. hurt the situation.**

Homework

For the child

- **Ask the child to pick one thing that happens in the upcoming week and to generate as many different thoughts as he or she can. Have the child make a column of helpful thoughts and a column of unhelpful thoughts.**

Help or Hinder Worksheet

Alex's mother blames him for something his little brother did.

- Alex feels hurt and angry.
- Alex thinks, "Mom is never fair."
- Alex says, "I hate you!" and runs to his room.
- Alex's mother punishes him.

What thought might have been more helpful?

_____

What might Alex have done to make the situation better?

_____

Jennifer's teacher announces that there will be a pop quiz today.

- Jennifer feels worried and angry with her teacher.
- Jennifer thinks, "I stink at math. I'm gonna get an F."
- Jennifer refuses to even try and turns the quiz in blank.
- Jennifer earns 0 points on the quiz.

What thought might have been more helpful?

_____

What might Jennifer have done to make the situation better?

_____

Marc's friend Curtis was supposed to call him to go skateboarding but never does.

- Mark feels left out and lonely.
- Mark thinks, "Curtis went skateboarding without me. He must not be a real friend."
- Mark ignores his friend next time he sees him.
- Curtis and Marc stop spending time together.

What thought might have been more helpful?

_____

What might Marc have done to make the situation better?

_____

Can you think of a time when you had an unhelpful thought?

How did the thought affect your behavior?

What might you have done instead?

Thought Bubbles

GOAL **To help the child understand the link between thoughts, emotions, and behaviors.**

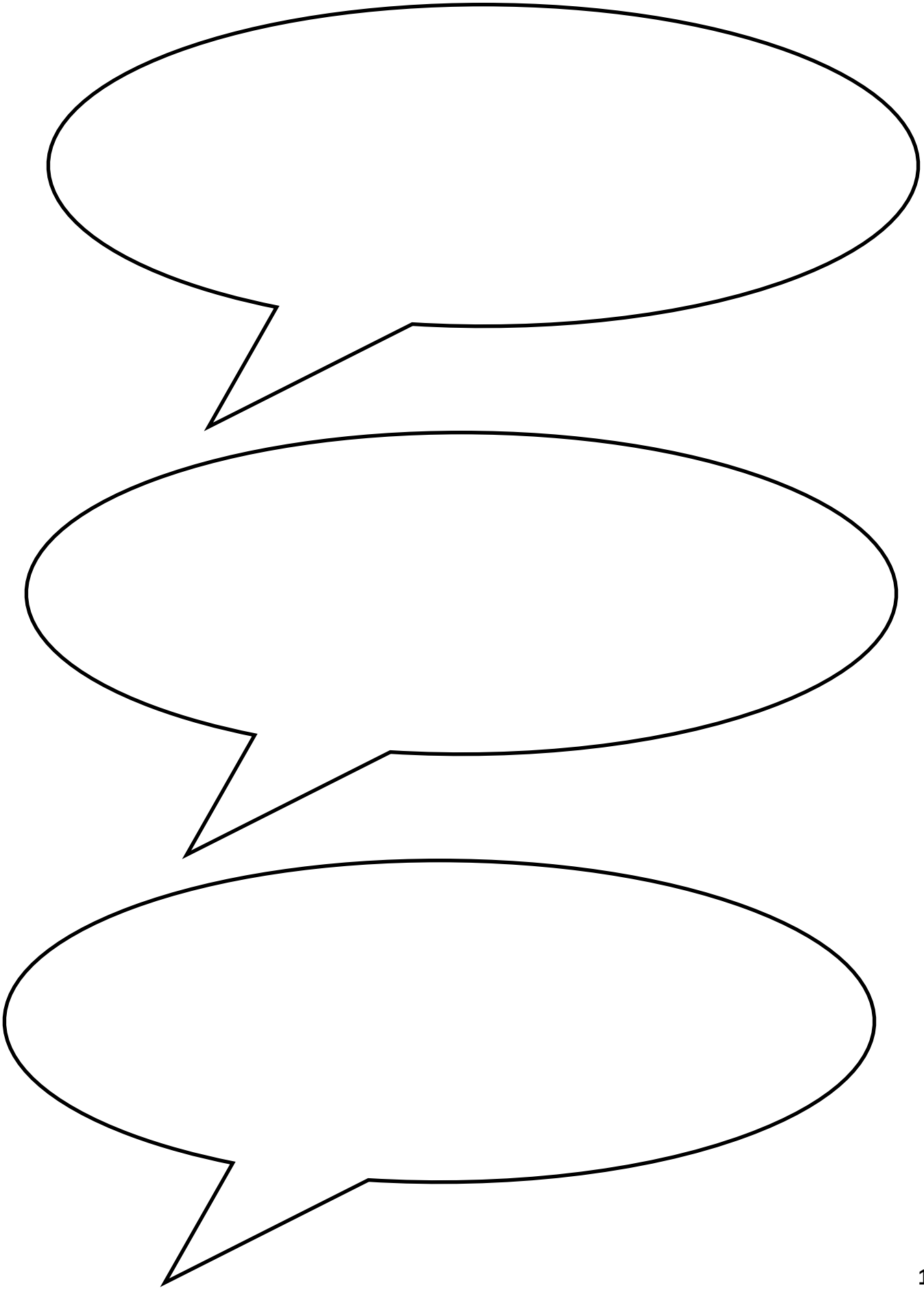
EXERCISE

What you need

- Pictures of people
- Thought bubble templates
- Tape

What you do

- Prior to the session collect a number of pictures of people with different expressions and engaging in different behaviors.
- You might obtain these pictures using magazines, newspapers, or the internet.
- During the session have the child cut out a bunch of cartoon thought bubbles using the templates on the following page.
- Alternatively, if the pictures are digital and on the computer, the child might use software to add thought bubbles to pictures.
- Engage the child in placing a thought bubble on each of the pictures and generating a thought for each one.
- Discuss why the child chose the thoughts that he or she did.
- In a conjoint session, you might ask the child and his or her caregiver to generate thought bubbles for the pictures and then discuss the comparison between their generated thoughts.



Thinking *Inside* the Box

GOAL **To help the child to interrupt intrusive thoughts, reserving them for processing in-session.**

EXERCISE

What you need

- **The "Thinking Inside the Box" worksheet**

What you do

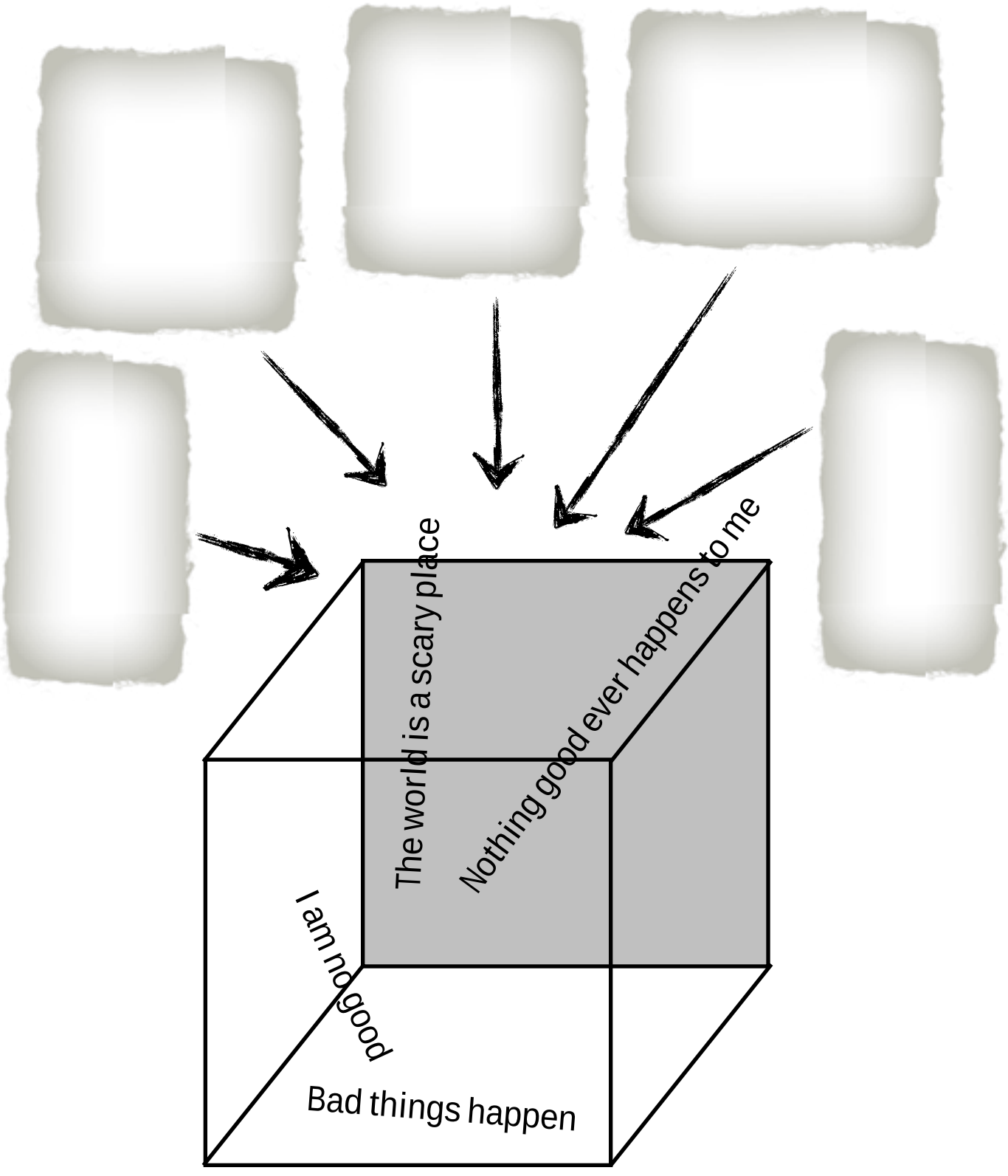
- **Explain to the child that some children who have experienced traumatic events replay thoughts about the event over and over in their heads - and that these intrusive thoughts interfere with daily functioning, like paying attention in school, enjoying activities, socializing with friends, etc.**
- **Also explain that intrusive thoughts often require that children talk to a therapist about them so to better understand what they are and what they mean - however, it is not always a good time to deal with these thoughts when they pop up. For example, if a child has these thoughts while in math class, he will not be able to concentrate on what the teacher is saying. Also, there is no one there to help him sort out these thoughts.**
- **Tell the child that one way to interrupt these thoughts is by putting them aside to deal with at a later time. Ask the child to think about a box in the back of his mind that he can store these intrusive thoughts in until he is ready to deal with them. Explain that one way to deal with them is to bring the box to therapy and sort the thoughts out with you.**
- **Introduce the *Thinking Inside the Box* Worksheet.**
- **Help the child to come up with up to five intrusive thoughts that pertain to him and write them on the scraps of paper to go into the box.**

Homework

For the child

- **Ask the child to imagine the box in the back of his head and to put any intrusive thoughts that he has before his next session into the box.**

Thinking Inside the Box



Affirmation Cards

GOAL **To help the child use positive thinking to lead to positive feelings about him or herself.**

EXERCISE

What you need

- Paper or tagboard
- Colored pencils or markers
- Examples of affirmation cards (see resources)

What you do

- Look at some examples of affirmation cards with the child and have her point out one or more that she likes.
- Talk about the purpose of affirmations: to remind us of all of the positive attributes each human being possesses and to help us maintain a positive attitude toward ourselves and our lives.
- Help the child list several strong motivational statements about herself.
- Some examples include:
  - I am growing stronger and more beautiful every day.
  - I am creative. I have lots of talents and abilities.
  - I let people into my life and I know that I am loved.
- Have the child choose one of the statements for her personal affirmation card that she then can create with the materials you provide.
- Make several affirmation cards.

Homework

For the child

- Ask the child to choose one card for each day and to put it in a place where she will see it first thing in the morning and last thing at night (e.g., bathroom mirror, alarm clock, etc.)

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Trauma Narrative

Narrative Brainstorming

GOAL **To help the child to generate and organize specific memories, thoughts, and feelings associated with his or her traumatic experiences.**

EXERCISE ONE

What you need

- Writing utensils
- The "Word Web" and/or "Timeline" worksheet(s)

What you do

- Have the child write a word that reflects the traumatic event in the empty circle in the middle of the Word Web Worksheet.
- Introduce the practice of free association and brainstorming.
- Using the empty circle as a starting point, have the child think of as many different trauma-related memories, thoughts, and feelings and then link them to the circle.

EXERCISE TWO

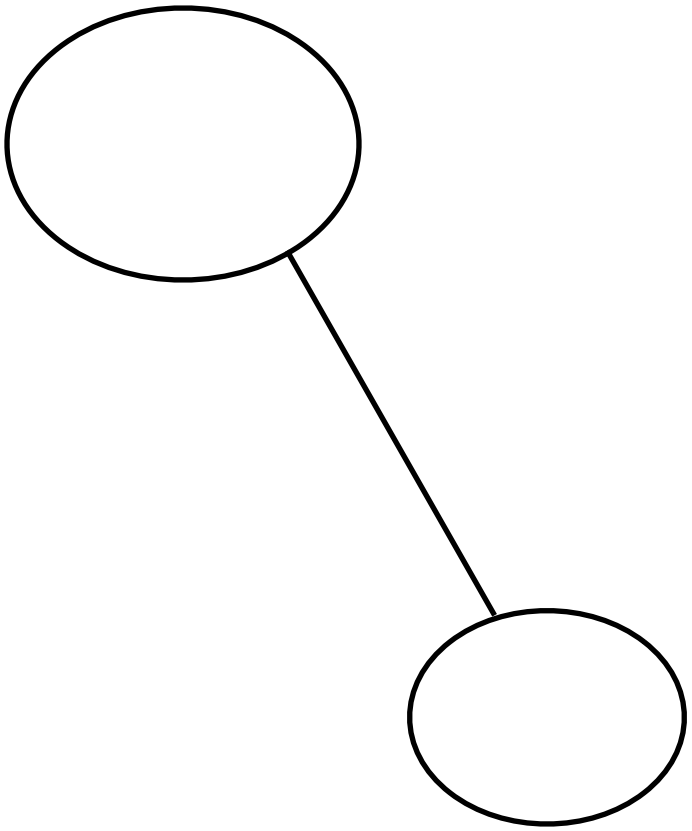
What you need

- Writing utensils
- Timeline Worksheet

What you do

- Use the Timeline Worksheet to help the child to place trauma-related events, memories, thoughts, and feelings in a chronological order.
- We recommend using Exercise Two with children who have experienced a series of traumatic events or prolonged exposure to trauma and Exercise One for children who have experienced a single traumatic episode.

Word Web Worksheet



Timeline Worksheet

Drafting the Narrative

GOAL **To help the child create a rough draft of the trauma narrative.**

EXERCISE

What you need

- Writing utensils
- The “Making the Draft” worksheet

What you do

- Instruct the child to use his or her brainstorming chart to write about what happened before, during, and after the trauma experience using the section headers on the worksheet to organize the information.
- By dividing the writing task into three sections the child may feel as though it is more manageable.
- Allow the child some personal space when writing the draft.
- If writing particularly burdens the child and you feel that it would compromise the development of the narrative, you may want to write for the child as he or she verbalizes the narrative.
- If the child is focusing on a number of traumatic events, you will need more than one worksheet.
- Instead of using the worksheet we devised, you may find it beneficial to design a custom template for the child you are working with. If the child is focusing on a number of traumatic events, you will need more than one worksheet.

Making the Draft Worksheet

Trauma:

Before:

During:

After:

Parallel Work with Caregivers

GOAL **To help the caregiver to explore his feelings about his child's trauma experience.**

EXERCISE

What you need

- Writing utensils
- The "First Time" Worksheet

What you do

- Explain to the caregiver that how she talks to and behaves towards her child can greatly influence her child's developing beliefs about self, others, and the world.
- Explore with the caregiver how her feelings and thoughts about the trauma might specifically impact her child's behaviors and developing beliefs.
- Ask the caregiver to complete *The First time* Worksheet.
- Discuss the caregiver's responses and provide the caregiver with a forum to share her thoughts and feelings related to the trauma.
- Examine distorted thoughts - ones that are permanent, pervasive, or too personalized. For example:

  Permanent - "My Child will never be happy again."

  Pervasive - "No one can be trusted with my child."

  "The world is not a safe place."

  Personalized - "This happened because I am a terrible caregiver."

  "I should have known that man was a sex offender."

- You might challenge these thoughts using socratic questioning. For example:

  "If your best friend had a child who experienced a similar traumatic experience, would you say to him or her what you are saying to yourself?"

  "Would you want your child to overhear you making this statement out loud?"

Adapted from UMDNJ-SOM CARES Institute 2006

The First Time

Worksheet for Caregivers

Using the space below, write about the time you first learned about your child's trauma experience. What were you feeling? What were you thinking? What were you doing?

The Finishing Touches

GOAL **Help the child to format his or her trauma narrative into a finished piece using a medium to his or her liking.**

EXERCISE

What you need

- Art or illustration materials (optional)
- Computer word processing, graphics, or presentation software (optional)

What you do

- There are a number of creative ways to format the trauma narrative. A child might use a word processing template to make the narrative look like a magazine page. A child might create an animated presentation with sounds and pictures using presentation software (e.g., Microsoft PowerPoint or Apple Keynote). A child might format the narrative to look like a comic book. A child might even turn the narrative into a song using audio recording equipment.
- The key to fully engaging the child in this activity is to make it interesting to him or her. Be creative with your suggestions and allow the child the freedom to use his or her imagination.
- We provided three examples of a trauma narrative in the form of a magazine article, a poem, and a slideshow presentation.

ME, FINALLYFREE

March 1, 2008

Me, Finally Free

Disgust, shame, dirt, blame
Is what I felt
When he touched me
On my vagina, breasts, face
Over and over again
While mom was out
Out of the house
Out of my life,
I hated him
He said he loved me
But what he loved had
Nothing to do with me.
This went on
And on and on, and on
Home was not home
Just a trap.
With a bed in it.

In time I learned
It could stop
Hope, strength, courage
Is what I felt
I sought help
And it came
Strong.
People all around
Embraced me
Took him away from me.
He was yesterday
Now is now
And home is home
Again.
I am me
Happy
Finally free.

January 2008

THE WORST TIME OF MY LIFE...

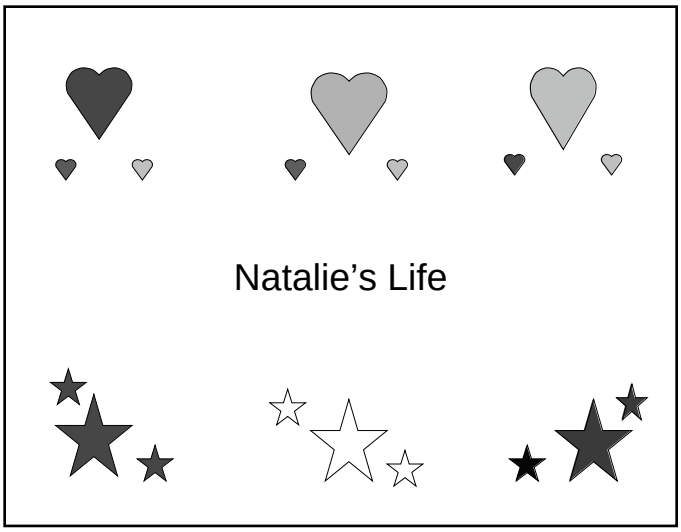
IT ALL STARTED WHEN I WAS 12-YEARS-OLD

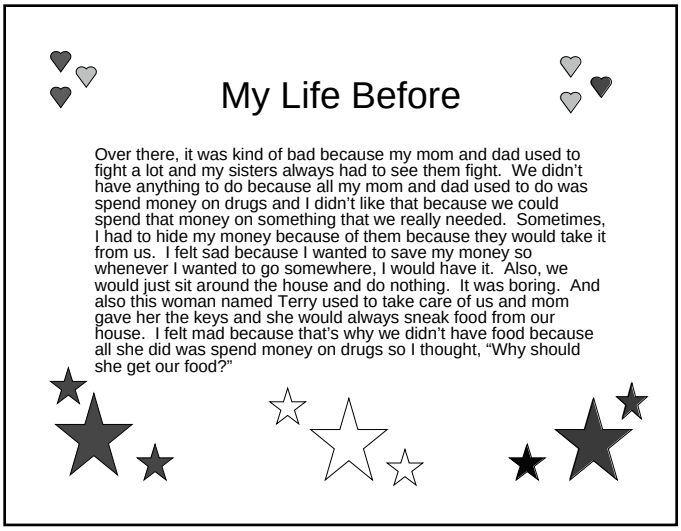
MY MOTHER MET THIS GUY NAMED JIM. JIM SEEMED LIKE A NICE GUY AT FIRST. THEN EVERYTHING CHANGED.

I remember when I first met Jim. I liked him. He seemed to really care about me and my mom. Then he started to push my mom around. This made me furious. I was also scared to death. I didn't get in the middle of it at first. I would go up to my room and cry. Then I couldn't take it any longer. I hated hearing my mother crying and being pushed into the walls. I grabbed my bat and went downstairs. When Jim saw me with the bat he just laughed. I froze with fear and felt paralyzed. Jim came over and grabbed the bat right out of my hands. I heard my mother scream, "don't touch him." Jim kicked me right in the gut. He threw the bat at the TV and it broke into a million pieces. Then Jim punched me in the face and my nose broke. My mother jumped on Jim's back but he just threw her off. I think he kicked me again and then must have realized what he did and took off in his truck. My mother got me to the hospital. I felt like a coward for freezing up. I felt like I failed my mother. But today I know it was not my fault and there was really nothing I could have done about it. Jim is out of our lives for good now. We are happy.

Today I understand what domestic violence is and what physical abuse is. I hope other families who are experiencing this kind of violence can get the help that they need.

Example of a Slideshow Narrative





My Mom and Dad

My mom and dad were very nice but the thing that I hate about them was they smoked a lot and it would give me headaches all the time. Also, my house would always smell like it and I didn't like it because I didn't like to smell like smoke. They would fight a lot, but sometimes they would get along. And also, they would tell people to give them money because they didn't have money and I didn't like that because people would come to our door everyday and ask, "Where's our money?" and I didn't like people coming to our house like that. Sometimes, they would even ask my friends for money and I hated that a lot because my friends would ask them, "where's my money?" too and so I would get mad at my parents because they asked for money from a lot of people.

Mom and Dad's Worst Fight

My mom and dad's worst fight was when he punched my mom in her face and left her a black eye. This is the worst fight because he had never left her a black eye before. The reason my dad said why he punched her was that he got mad at my mom because my mom was ignoring him and he didn't like that. So he got mad and then just punched her and my mom met this guy at the bus. He said, "What happened to your eye?" and my mom said, "Nothing" and he said "Tell the truth." So my mom told him and he got mad. The next day, my mom brought him over to the house and I got kind of jealous because I'm used to being with my dad, not with other men. And I wanted to stay up because I didn't know what they were gonna do. Now when I think about my mom bringing the guy over, I feel mad because I didn't like him.

When I Found Out My Mom Died

I found out my mom died by looking at the ambulance and looking at the policemen. When I came close to my door, everyone cried, so when my friend took me to her house, she was crying a lot because she knew my mom died. I was feeling sad because everyone was crying. I asked her, "What happened?" and she wouldn't tell me and I felt mad. And then when I went back outside again, I saw my dad handcuffed, going into a police car, so that's how I know that my mom died and I felt sad. Then, at my friend's house, this lady came up to me and said, "Sorry, your mom passed away." I felt sad. Her name was Michelle, my mom knew her. And then, when these people picked me up, they told me I might go to a foster home and that's when I really knew my mom died and I felt even sadder.

My sisters and brother

My sisters were very quiet sometimes and cranky because my mom would do drugs and my brother would be mad all the time because he would tell my mother to help him with his homework and my mother helped him and he wanted the answers, he didn't want my mom helping him.

My Life Now

My life now is much easier and more fun because we get to go out to eat and we get to go to the mall and also we are healthier and we have all our shots and we get good grades and my sisters are going to school. We don't have to beg for money to people. Now that I came to Delaware, I have a lot of family. I didn't really know them that well but now I do because I went to their house and met them. I like spending time with my cousins, especially Leslie because sometimes she'll take me outside and sometimes she lets me go wherever she goes, but that's only sometimes. I love my aunt and uncle cause they brought me with them to Delaware and if it wasn't for them, we would be in foster homes. Now, we're in a better place with them and I love them!

What I've Learned

I've learned not to do drugs and not to fight. And always don't beg from people because that is really disrespectful and I've learned that how my parents fought was wrong because they could have been nicer to each other instead of fighting a lot. They could have gotten along and been more respectful of each other. And you can disagree by saying, "I disagree with this." That's what I've learned.

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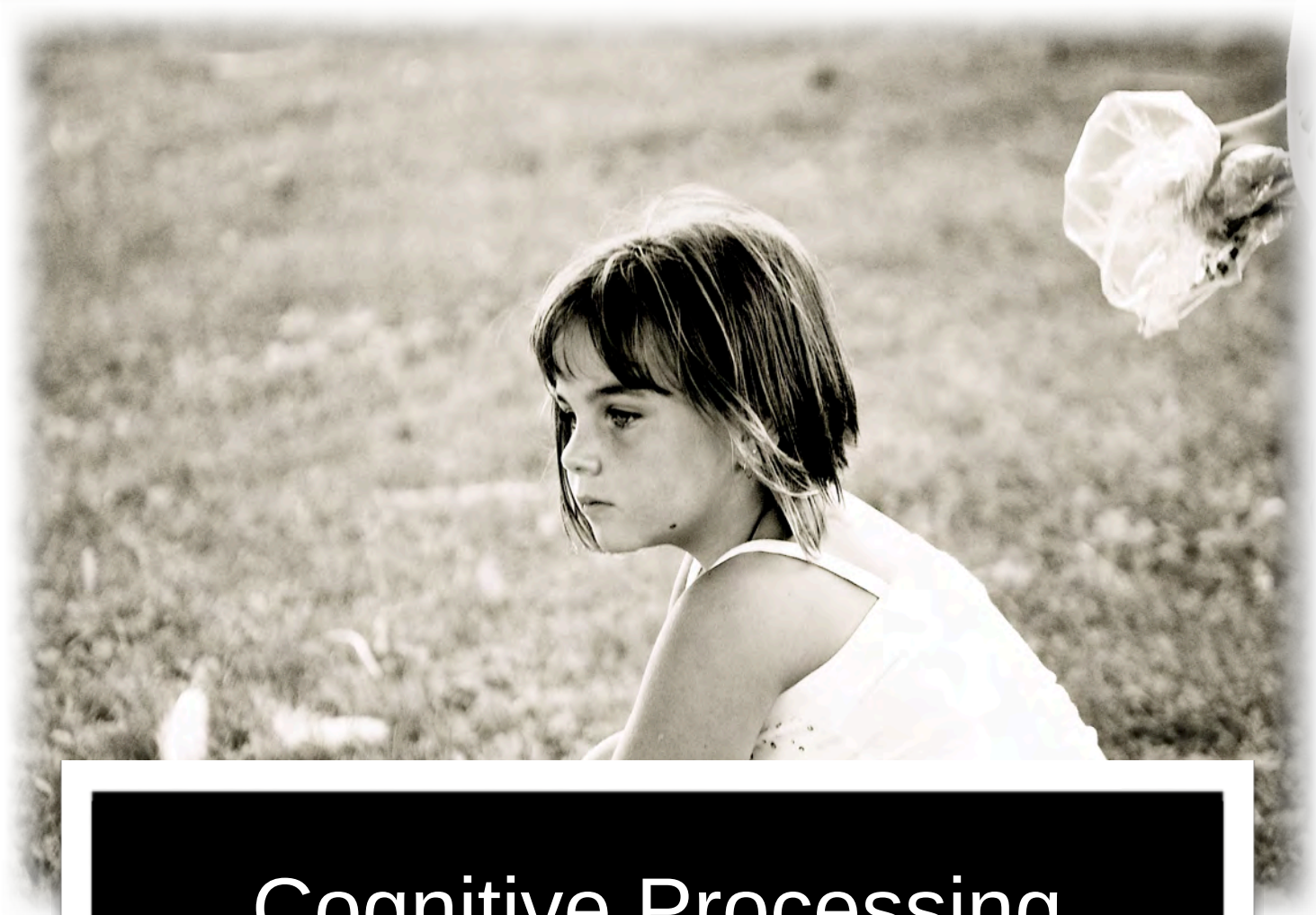

Cognitive Processing

Revising the Narrative

GOAL **Help the child to revise the narrative by inserting feelings, thoughts, and behaviors, and rethinking statements that are distorted or maladaptive.**

EXERCISE

What you need

- **Colored writing utensil or word processing computer software**
- **Trauma narrative draft**
- ***Melissa's Story* (optional) example narrative with revisions**

What you do

- **Have the child read through the narrative. While the child is reading, interrupt the child with questions or prompts that indicate where words could be inserted, omitted, or modified.**
- **For example: *How did that make you feel at the time? What were you thinking at the time? What were you doing at the time? How do you feel about that now? What thoughts do you have about that now? Could you really have known that? Was it your responsibility to stop that from happening?***
- **With some older children you might have them first read through and make modifications in the narrative with the instructions to insert feeling words, thoughts, and behaviors.**
- **If the narrative is typed into a word processing program, you and the child could easily insert and delete items. You could even color-code revisions. For example, you might make all additions of feeling words red and all additions of thoughts blue.**
- **If the narrative is handwritten, use a colored writing utensil to cross out sections and to add words.**
- **You may need to remind the child what a cognitive or thought distortion is based on work you did in the cognitive coping component. One way to describe it is an interpretation of the situation that is unhelpful and not fact.**

Homework

For the child and caregiver

- **Ask the child and caregiver to pay particular attention to cognitive or thought distortions throughout the week, particularly when he or she is interacting with other people.**

Melissa's Story

Here is an example of a narrative that has been edited during the Cognitive Processing session. The larger, bold words and phrases were added during revision. Words that were eventually deleted have a line through them.

CHAPTER ONE: INTRODUCING MELISSA!

My name is Melissa. I'm 11-years-old. My birthday is September 18th. I have a mom, dad, a stepmom, two stepsisters, a brother and a sister. I live in Wilmington, Delaware. Right now I live with my mom and Jan. I like to draw. I like dodgeball. I have a lot of friends. I think counseling is good because it teaches me about stuff. I haven't figured out what I want to be when I grow up. It's either a teacher or an artist. I make my caregivers smile.

CHAPTER TWO: WHAT HAPPENED TO ME

My sexual abuse ~~the bad thing~~ happened one time this summer and another time a long time ago. I can't remember if there were any others. I was at my Gram's house. A friend of hers touched me **on my vagina. I felt bad. My stomach felt fuzzy. I thought he was bad and I thought he was nice. I felt sad. I felt confused, a little angry, and embarrassed.** ~~down there. I should have tried to run but I didn't. I just laid there.~~

When Steve touched **my vagina** ~~me down there~~ we were in Gram's bed. I was sleeping and he woke me up by touching me. **I was shocked.** I told him to stop and he just made a mean face at me and I started crying. ~~I should have screamed or something.~~ Then he stopped and I left the room. I went into the playroom with my sisters and brothers. **I felt better because I knew I could sleep then.** ~~I was not brave enough to tell anyone.~~

I never thought he would do something like that. I thought, "I'll never tell, I'll never tell." I was afraid that everyone on my dad's side would be mad and never want to see me anymore. I didn't want to go to court and have everyone mad at me. I thought I wouldn't be able to see my Gram. I felt upset a lot. I tried not to think about it because it would make me upset even more.

CHAPTER THREE: TELLING

I think it happened to my sister before it happened to me. At home I wasn't talking like I usually do. **I kept thinking about what Steve did and what I would do if I saw him again. I was afraid I would just cry.** And about a week later my sister asked me if it ever happened to me. First I said no, and then I said, "Okay, yes, he did it to me but don't tell anyone." **When she told our mom I was mad and scared that my Dad would be really mad at us and not see me anymore.** But later I apologized to my sister. My Dad was mad. **I felt glad that my sister told but I was still scared that my Dad wouldn't believe me. I know that it is hard for my Dad because Steve is like a dad to him. I learned that my Dad was mad at Steve not at me.**

CHAPTER FOUR: WHAT I'VE LEARNED

I've learned a lot. I've learned that it's okay to tell someone if you were sexually abused like I was. Even though the person might seem nice at first, you should still tell because that person did something wrong to you.

I've learned that it wasn't my fault, it was Steve's fault for doing it to me. **I was 10-years-old and I didn't really know what to do. Steve should have known not to sexually abuse me because he could hurt me.**

When you feel tight, let yourself go, like spaghetti. If your thoughts are making you unhappy you can put them in a box and keep it at the back of your mind. You can look at them when you feel like discussing them with somebody.

If a man or a lady touches you in a not okay way, say no. And if you are sexually abused, tell somebody. Talking to someone is helpful too.

THE END

Hunt for Unhelpful Thoughts

GOAL **Help the child to revise the narrative by identifying unhelpful thoughts or beliefs apparent in the narrative.**

EXERCISE

What you need

- **The "Hunt for Unhelpful Thoughts" worksheet**
- **Trauma narrative draft**

What you do

- **You may want to use this exercise only if you have read the child's narrative and found distorted thoughts or beliefs that can be corrected.**
- **Tell the child that you would like her to 'hunt' for unhelpful thoughts that might have found their way into her trauma narrative.**
- **Review what an unhelpful thought is.**
- **Explain that it is easy for unhelpful thoughts to sneak their way into memories of traumatic events.**
- **Have the child use the *Hunt for Unhelpful Thoughts* Worksheet.**
- **Help the child to cut out the inner circle of the magnifying glass.**
- **Then, have the child move the page around the narrative so that only some of the words are presented in the circle.**
- **Help the child to write down any unhelpful thoughts that she finds on the lines below.**
- **Later, help the child to make any changes to her trauma narrative.**

The Hunt for Unhelpful Thoughts

What did you find?

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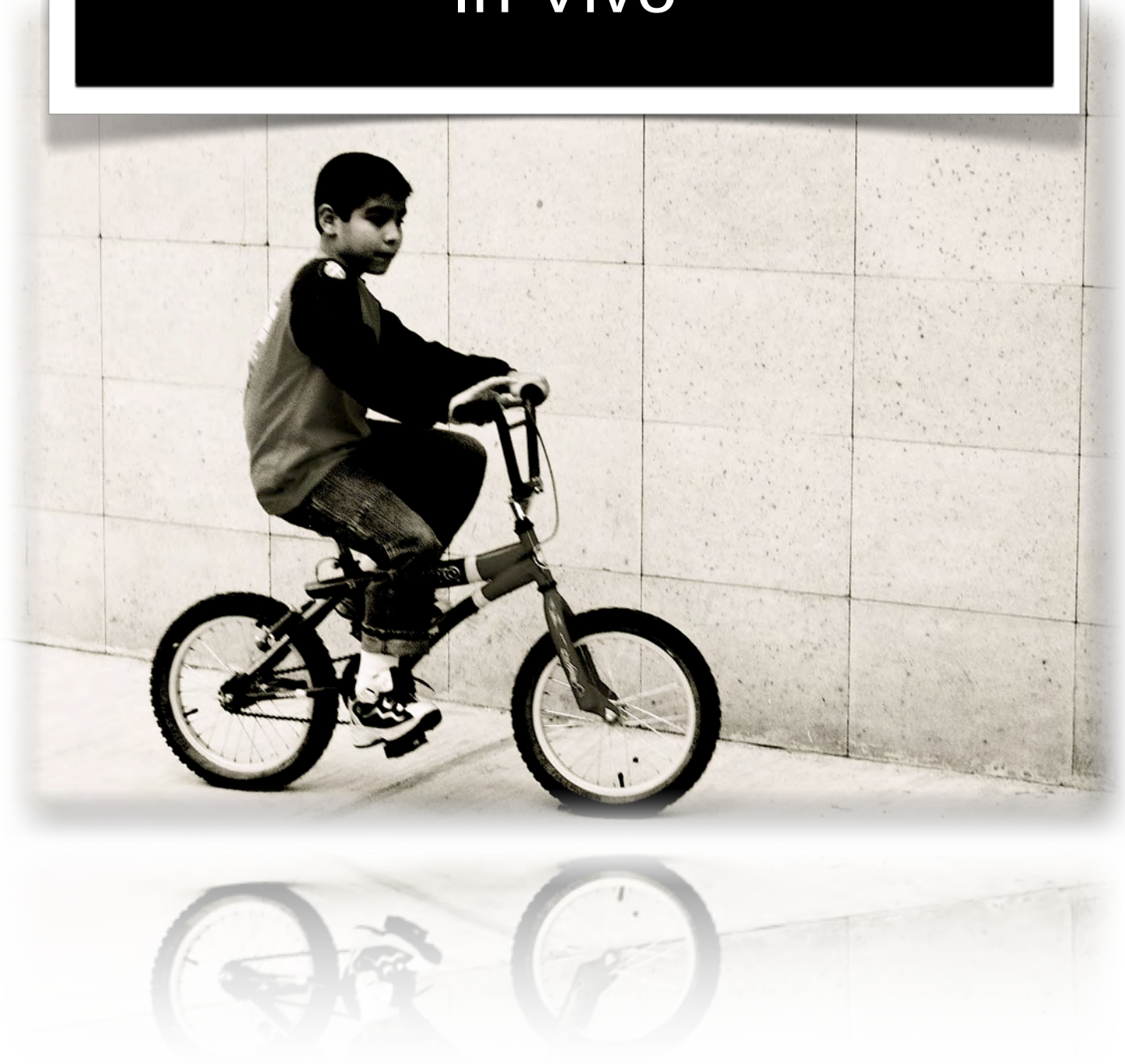
In Vivo



Changing Placement

GOAL **To emotionally prepare the child to move to a new placement.**

EXERCISE

What you need

- Camera (optional)
- Pen and paper

What you do

- Discuss with the child his or her thoughts and feelings about moving to a new placement.
- Work with the child to create a survey of everything he or she would like to know about the new placement (e.g., Will there be pets? Will I have to share a room? Who else lives in the house?).
- Ask the new caregiver, residence staff person, or caseworker to fill out the survey.
- You might also ask someone to take pictures of the residence and household members for the child to see prior to the move.
- If possible, arrange for the child to visit the new placement and meet with his or her new caregiver.
- You might arrange a similar task for a child who is transitioning to a new school placement.

Remembering the Deceased

GOAL **To encourage caregivers and child to express and process grief by honoring the memory of the deceased.**

EXERCISE

What you need

- **Photographs or keepsakes of the deceased.**

What you do

- **Discuss with the child the normal process of grieving.**
- **Explain the importance of remembering the deceased.**
- **Help the child to choose a medium in which to create a memorial of the deceased (e.g., memory box, video, computer presentation, scrapbook).**
- **Encourage the child (and caregiver if appropriate) to discuss memories of the deceased and ways he or she might preserve these memories (e.g., drawing, writing poems).**
- **You might ask the child (and caregiver) to collect materials to include in the memorial.**
- **Use the materials to create a memorial of the deceased.**
- **This might result in a physical product or a memorial service that is conducted in session.**
- **Afterward, discuss with the child (and caregiver if appropriate) his or her thoughts and feelings during and after the memorial.**
- **Ask the caregiver to praise the child for sharing and to assist in recalling and preserving memories of the deceased.**

HOMEWORK

For the child

- **Encourage the child to share his or her thoughts and feelings about the deceased at home with his or her caregiver.**

For the caregiver

- **Ask the caregiver to praise the child for sharing and to assist in recalling and preserving memories of the deceased.**

Reclaiming your Land

GOAL **To help the child reduce triggers instigated by places, people, or things that were associated with the traumatic event.**

EXERCISE

What you need

- Story of a famous explorer or storybook character
- Craft materials as needed

What you do

- If a child continues to avoid associated people, places, or things after completing the trauma narrative, consider planning an in-vivo exposure.
- You might use the analogy of “reclaiming land” - much like famous explorers and courageous storybook characters have.
- You might tell the child a story of a particular explorer or character to convey this notion.
- Motivate the child to “reclaim” what is his or hers in a similar way.
- You might work together to create a flag that has personal significance to the child and set a date to go to the person, place, or thing that the child has been avoiding.
- Break down the task into specific steps. This will help to reduce anxiety.
- Involve the caregiver and other individuals if appropriate.
- If the child is particularly anxious, make the exposure more gradual by, for example, looking at pictures of the place or using visualization techniques.
- Discuss with the child his feelings before and after completing this exercise.

Who's Who in Court

GOAL **To emotionally prepare the child to appear in court.**

EXERCISE

What you need

- Index cards
- Paper and markers

What you do

- On one side of the index cards help the child to write down all of the different individuals in a courtroom (e.g., judge, attorney, bailiff, defendant, plaintiff).
- Have the child turn the cards over and write down a brief description of each of their roles in court (e.g., bailiff: helps the judge keep the courtroom safe and organized).
- You might use a dictionary or the internet to research the different roles.
- Encourage the child to use the index cards to remind him or her of the individuals in the courtroom and their respective roles.
- You might also research the layout of the courtroom using the internet or some other source.
- Help the child to locate where in the courtroom he or she and each of the individuals will be located.
- You might encourage the caregiver to arrange a visit to the courtroom where the child will appear. If the child is expected to testify, have him or her experience what it is like to take the stand. Remind the child to use the relaxation techniques he or she has learned.

NOTE: In most cases, the state's attorney will be preparing the child to appear in court. Their preparation, however, may not include a visit to the courtroom or an outline of what courtroom officials' roles are.

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Conjoint Sessions

Do You Know Me?

GOAL **To find out how well the child and caregiver know each other, and to encourage trust and greater intimacy.**

EXERCISE

What you need

- Two pads of paper or lap-size white boards
- Writing implements
- A list of questions

What you do

- Give the child and caregiver each a pad of paper or white board.
- Read aloud the following list of questions:
  1. What is your favorite color?
  2. What do you like to do when you have free time?
  3. What are you afraid of?
  4. What are your favorite clothes to wear?
  5. What is one of the worst things that has ever happened to you?
  6. What was (is) your favorite subject in school?
  7. Who is your best friend?
  8. Are you a night owl or an early bird?
  9. What is your favorite thing to eat?
- You may also come up with additional questions or have the child or caregiver generate questions during the game.
- Ask the child and caregiver to write the answers that he or she thinks the other will give.
- Have the child go first, then the caregiver, reading to the other what he or she has written.
- Do one question at a time.

Playing Games Together

GOAL **To encourage good communication throughout the therapeutic process between caregiver and child.**

EXERCISE

What you need

- Any of the exercises or games played in skill-building sessions on relaxation, affect modulation, or cognitive coping - or a game selected from the resources section.

What you do

- In any of the skill-building sessions, ask the child if he would like to teach the skill he has been practicing to his caregiver.
- Invite the caregiver into the room and assist the child in guiding the caregiver through the exercise or in giving instructions for playing a game.
- You may join in the exercise or game, or may serve as a scorekeeper or moderator.

Reading the Narrative

GOAL **To promote healthy communication between caregiver and child regarding the traumatic event.**

EXERCISE

What you need

- The child's narrative

What you do

- As the narrative is developed, you can read it each week to the caregiver to help her become more comfortable with hearing it.
- In a final prep session with the caregiver, remind her to offer the child specific praise (e.g., You described what happened so well!) and to use active listening when the child reads the narrative aloud.
- You might choose to rehearse with the caregiver once more immediately prior to the session.
- Prepare or rehearse with the child individually prior to the conjoint session.
- Bring the caregiver and child together in the therapy room and allow time for everyone to become comfortable.
- Have the child read the narrative to the caregiver, without interruption. At the same time, be prepared to intercede if the caregiver or child suddenly decides he or she cannot follow through with the session activity.
- Allow the caregiver and child the opportunity to exchange praise. You may add your own praise for each of them.
- End the conjoint session on a positive note, perhaps by playing a game, or giving the child a token gift.

Homework

- Ask the caregiver to observe any discussion about the trauma outside of session. Encourage the caregiver to use praise and active listening when discussing anything related to the trauma with the child at home.

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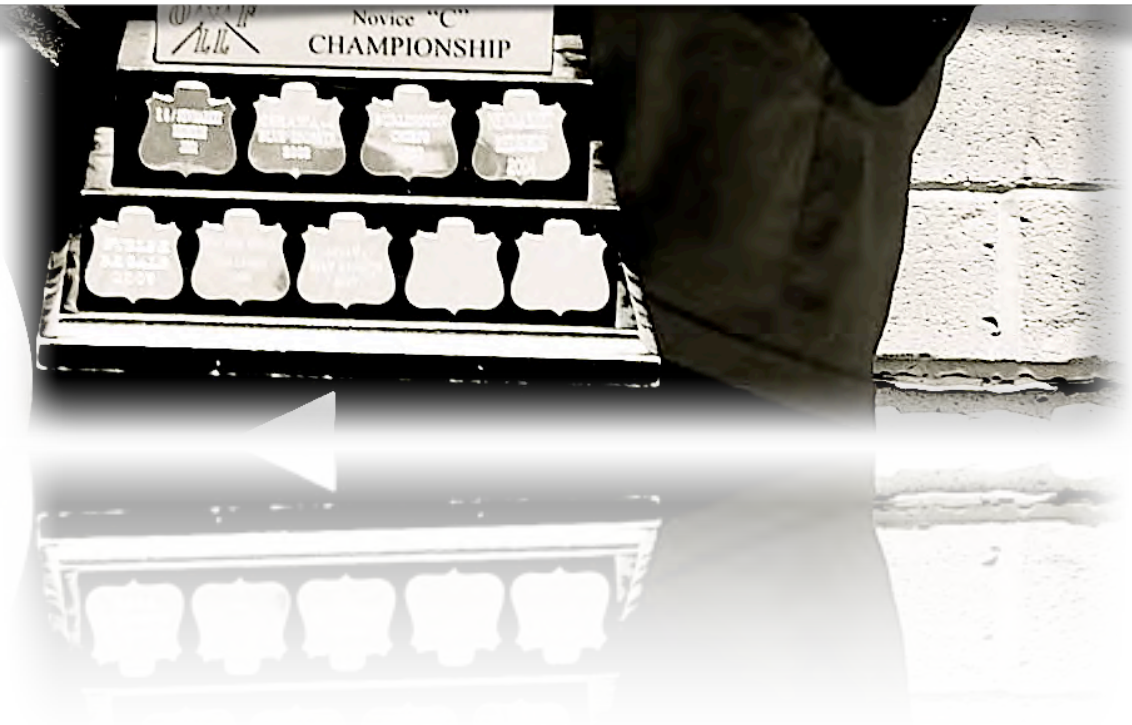
Enhancing Future Safety & Development



Three Doors

GOAL **To facilitate communication about important losses or disappointments, what is valuable and worth holding onto from the past, and hopes and dreams for the future.**

EXERCISE

What you need

- **The "Three Doors" worksheet**
- **Paper**
- **Writing instruments**

What you do

- **Ask the child to imagine what is on the other side of three doors.**
- **The first door is the door to their past that opens to whatever disappointments, losses, or setbacks that they have experienced.**
- **The second door opens to the things that they want to hold on to from their past. These could be happy memories, relationships, skills, or lessons learned that they value and wish to keep.**
- **The third door opens to their hopes and dreams for the future.**
- **The child can either describe to the therapist what is behind each door, or write, draw or use miniatures to symbolize what is to be found on the other side of each door.**
- **The therapeutic value of this activity will rest largely on the ability of the therapist to take what the child expresses and expand on it to create meaningful exchange around issues central to the child's emotional life.**

Adapted from Three Doors as developed by David A Crenshaw, Ph.D., Director, Rhinebeck Child and Family Center, LLC.

Three Doors Worksheet

Who is there for me?

GOAL **To help the child find and keep social support and know who to go to for help in particular situation.**

EXERCISE

What you need

- Pen and paper
- Alternate: Pictures of various people in child's life

What you do

- Ask child to list all of the people in his/her life who he/she cares about and who cares about him/her (example: mother, father, siblings, teachers, priest, babysitter, etc...). Some child may have a problem coming up with people but give them options/help them.
- Next to each person, have the child describe how and when that particular person helps him/her. Also have him/her explain the importance of having that person's help (what would he/she do without that help?)
- Describe a tough situation to the child (or have him/her describe a situation) and have him/her explain how each person on the list could help.
- Explain to the child that not every person is always going to be able to help and the child won't always be able to go to the same person. Help the child figure out which people are good to go to in various situations and show them there are a lot of people out there who care.

Creating a Safety Plan

GOAL **To help the child feel safe from future victimization by having a safety plan.**

EXERCISE

What you do

- This activity can be conducted during a conjoint session or with the child individually.
- Review the traumatic event with the child (and caregiver).
- Offer praise for the steps the child took to make him or herself safe.
- Tell the child that you want to help to devise a plan for what to do if he or she feels threatened in the future.
- The details of the safety plan will vary depending on the type of trauma and the child's situation.
- For example, if the child experienced sexual assault, you might help the child to identify places in the community where she can go to get away from danger and get help (e.g., counselor at school, reliable neighbor, relative). Discuss how the child will get to a safe place.
- A safety plan might also involve members of the family. For example, if the child is worried that the perpetrator might return, (e.g., domestic violence situations) you might encourage the family to generate specific roles for each member of the family carry out in an emergency.
- A safety plan may help the child now how to take action should he or she feel threatened in the future.
- If the safety plan involves other members of the household, ask the child and the caregiver to hold a family meeting to discuss each member's role in the plan. You might have the child decide on specific instructions for each member of the family.

Being Assertive

GOAL **To help the child to communicate assertively.**

EXERCISE

What you do

- **Discuss with the child what it means to communicate assertively. Ask the child how he or she might stand up to someone who is not respecting his or her personal boundaries.**
- **Discuss body language and the differences between aggressive, passive, and assertive behaviors.**
- **Engage in a role-play to have the child practice communicating assertively in different situations.**
- **Some key principles include:**
  - **Using body language that is calm, aware, and confident;**
  - **Making eye contact;**
  - **Keeping your facial expression consistent with your message;**
  - **Using language that is respectful, but definite. Examples include, "Excuse me! Please stop! I need your help!";**
  - **Moving away from the person while asking him or her to respect your boundaries;**
  - **Making your voice loud enough to be heard and clearly understood.**

Recognizing Danger

GOAL **To help the child recognize internal cues that signal the need to get to a safe place and to get help.**

EXERCISE

What you do

- **Some children, especially those who have had repeated exposure to violence, have difficulty recognizing dangerous situations.**
- **Engage the child in a role-play in which he or she must seek safety in the context of the traumatic event.**
- **Start by describing the situation to the child.**
- **You can make up your own scenarios or use one or more of the following:**

1. You are watching TV in your bedroom when you hear your mother and stepfather arguing downstairs. Their voices are getting louder. Then you hear the sound of glass breaking and what sounds like things being knocked over.

2. You are walking home from school. Lots of other kids are walking on the same block. Suddenly, two boys start to yell at each other. One jumps on the other's back. They both fall to the ground and are punching each other. A few of their friends try to pull them off of each other. Somebody pulls out a knife.

3. Your older brother has been in a lot of trouble for drug use. He is on probation. You are babysitting for your little sister while your caregivers are out. You hear the front door open and your brother comes in with two friends you've never seen before. They all seem to be high on something. The two friends sit down on the couch on either side of you. They are laughing. One of them puts his arm around your shoulder while the other one moves closer. Your brother pays no attention.

- **Ask the child to identify the point at which the situation becomes dangerous.**
- **Ask how his body feels when recognizing danger.**

Internet Safety

GOAL **To encourage children and caregivers to use the internet safely.**

EXERCISE

What you do

- Research internet safety information and statistics.
- During a conjoint session, engage the caregiver and child in a discussion about internet safety using the information you found.
- Some key safety guidelines include:
  - Never reveal personal information (e.g., real names, birth dates, phone numbers, addresses, or anything identifiable);
  - Never meet up with a stranger;
  - Establish codes of conduct (e.g., if you wouldn't say something to someone's face, then don't say it to them online);
  - Be careful with passwords - never share them with anyone;
  - Only respond to emails and instant messages from people you know;
  - If you receive an email or instant message that makes you feel uncomfortable, show it to an adult whom you trust;
  - Avoid chat rooms or discussion areas that seem sketchy or provocative.

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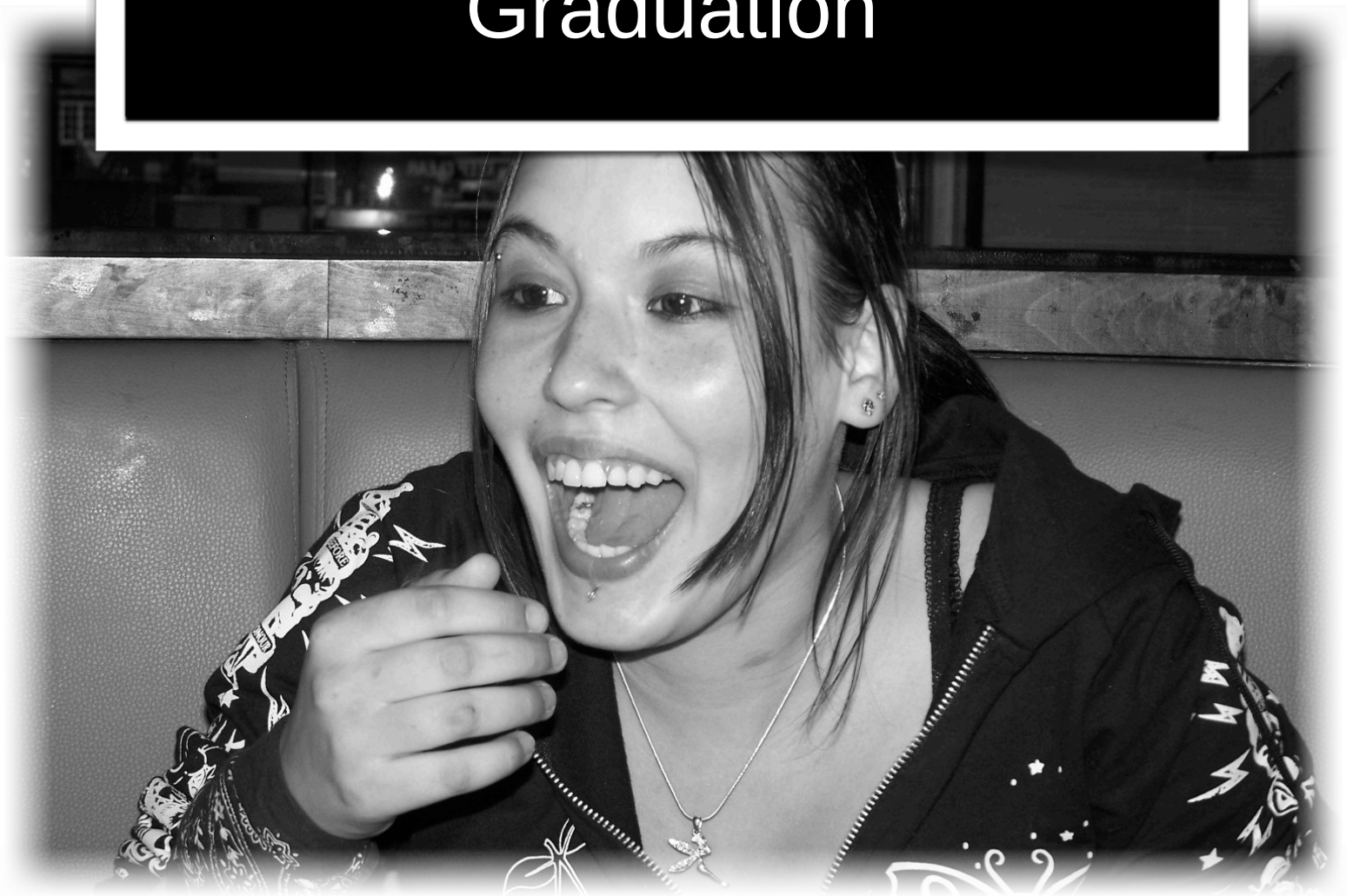
Graduation



Let's Celebrate

GOAL **To end therapy on a positive note and encourage the family to celebrate this accomplishment.**

EXERCISE

What you need

- Graduation Certificate (one is provided or create your own)
- Balloons (optional)
- Cake (optional)
- Token gift for child (optional)

What you do

- Ask the caregiver and child to invite any additional family members they would like present for the child's graduation.
- Allow the family to bring light refreshments if they wish.
- Present the child with the graduation certificate, stating a few words of praise for a job well done.
- Celebrate!

CERTIFICATE
of COMPLETION

This certifies that

Has successfully completed

DATE

Additional Material and Handouts

Sex Education

Helping Caregivers Talk about Sex

GOAL **To help caregivers engage in discussions about sex with their child.**

EXERCISE

What you need

- **The "Talking about Sex & Abuse" handout for caregivers**

What you do

- **Explain to the caregiver the rationale for talking openly about sex with their child.**
- **Explain that it is natural or caregivers to feel embarrassed or nervous about talking to their children about sex, but that they should work on becoming more comfortable with it.**
- **Explore the caregiver's own feelings about engaging in sex-related discussion with her child. Troubleshoot any concerns or reservations she might have.**
- **Explain that for homework the caregiver will be asked to go over several sex-related questions with her child that are posed on the *Talking about Sex & Abuse* handout. Tell the caregiver that to practice, you will ask her the questions on the handout.**
- **Demonstrate your comfort with the topic by making eye contact with the caregiver when posing the questions on the *Talking about Sex & Abuse* handout.**
- **Praise the caregiver's effort to respond.**
- **Demonstrate your comfort by repeating the caregiver's responses to the questions.**
- **Afterward, ask the caregiver how she felt answering the questions.**
- **Feel free to add your own questions to the handout.**

HOMEWORK

For the caregiver

- **Ask the caregiver to go over the *Talking about Sex & Abuse* handout with her child.**
- **Encourage her to repeat this exercise on a number of occasions.**

TALKING ABOUT SEX & ABUSE

A Handout for Caregivers

Instructions:

The following questions pertain to sex and sexual abuse. Demonstrate your comfort with the topic by making eye contact with your child and posing questions in a calm, clear tone of voice. Praise your child's effort to respond, while actively ignoring silly or avoidant behavior. After praising your child's effort, provide constructive feedback if your child's response reveals misconceptions or lack of information. Show your comfort and pride by repeating your child's accurate responses to the questions. Finally, ask your child if he has any questions about child sexual abuse that he would like to ask you. Be prepared for some questions you may not be able to answer immediately. It is fine to say, "That's a very good question - I am going to have to think (or get information) about that before I answer it."

For adolescents focus on questions # 5, 6, 7, 8, 9, 12, 13, and 14.

Questions:

1. **Tell me the doctor's names for a boy's private parts.**
2. **Tell me the doctor's names for a girl's private parts.**
3. **Tell me at least one "okay" touch.**
4. **Tell me at least one "not okay" touch.**
5. **What is child sexual abuse?**
6. **Who sexually abuses children?**

7. **Whose fault is it when a child is sexually abused - the child or the older person?**
8. **When is it okay for someone to touch your private parts?**
9. **When is it okay for grownups to touch each other's private parts?**
10. **How do you feel when you get an "okay" touch?**
11. **How do you feel when you get a "not okay" touch?**
12. **How do children feel when they are sexually abused?**
13. **[If sexually abused] How did you feel when you were sexually abused?**
14. **[If sexually abused] How did you feel when you told about the sexual abuse?**
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. _____

Adapted from Deblinger and Stauffer (2004) UMDNJ-SOM CARES Institute

The Parts of the Body

GOAL To help the child understand the parts of the body.

EXERCISE

What you need

- Body Diagram (gender specific) The diagram could be an outline of the child (life size).
- Small sticky notes with various body parts written on them.

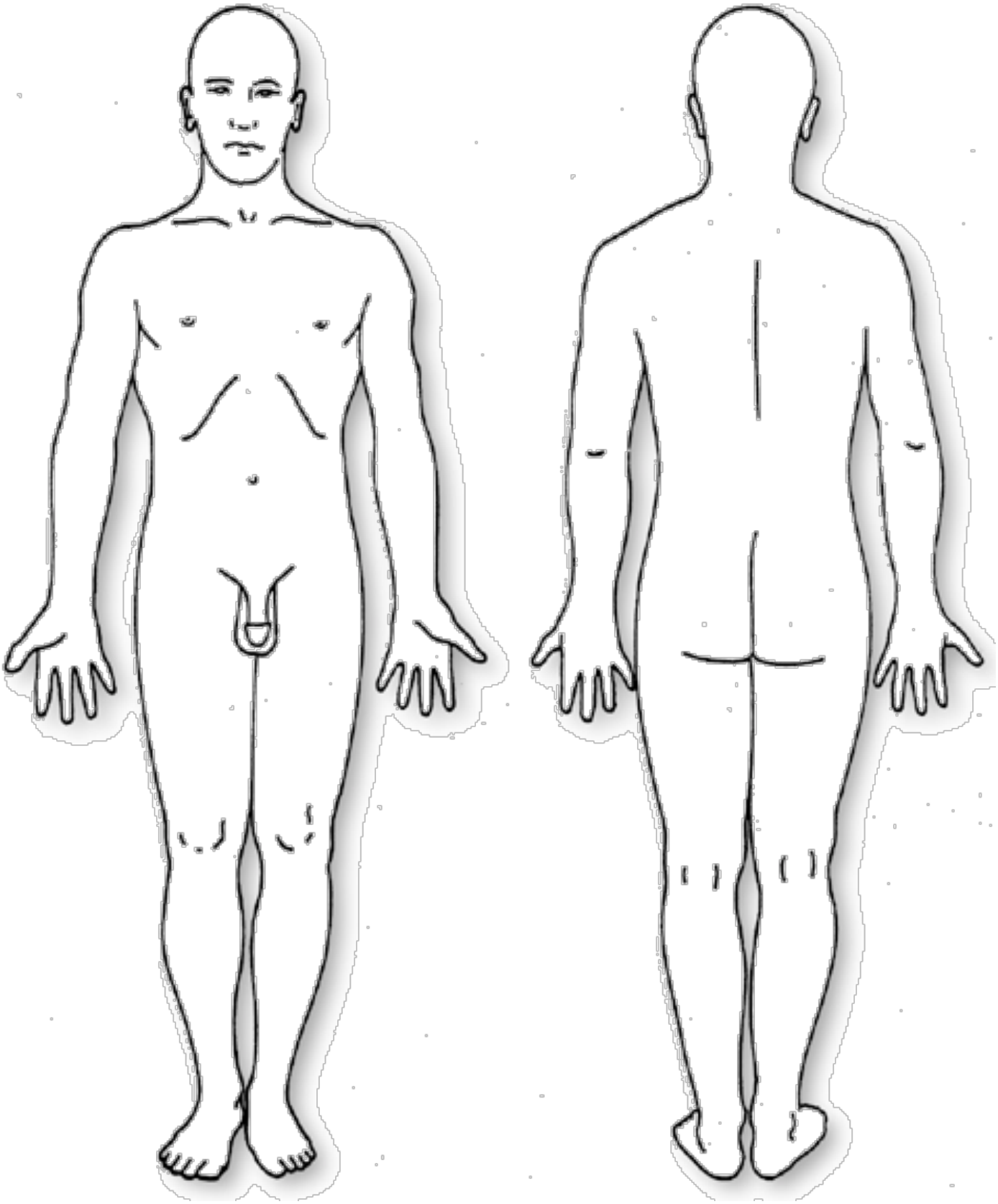
What you do

- Tell the child that you are going to play a game involving the parts of the body.
- Show the child the body and tell him/her that you will be taking turns turning over sticky notes with various body parts on them and placing them where they belong on the body.
- Tell the child for every one he places correctly, he/she gets one point.
- After the body part is properly placed, tell the child to explain the function of that body part. For every correct answer, award the child an additional point. Correct the child for every inaccurate response.

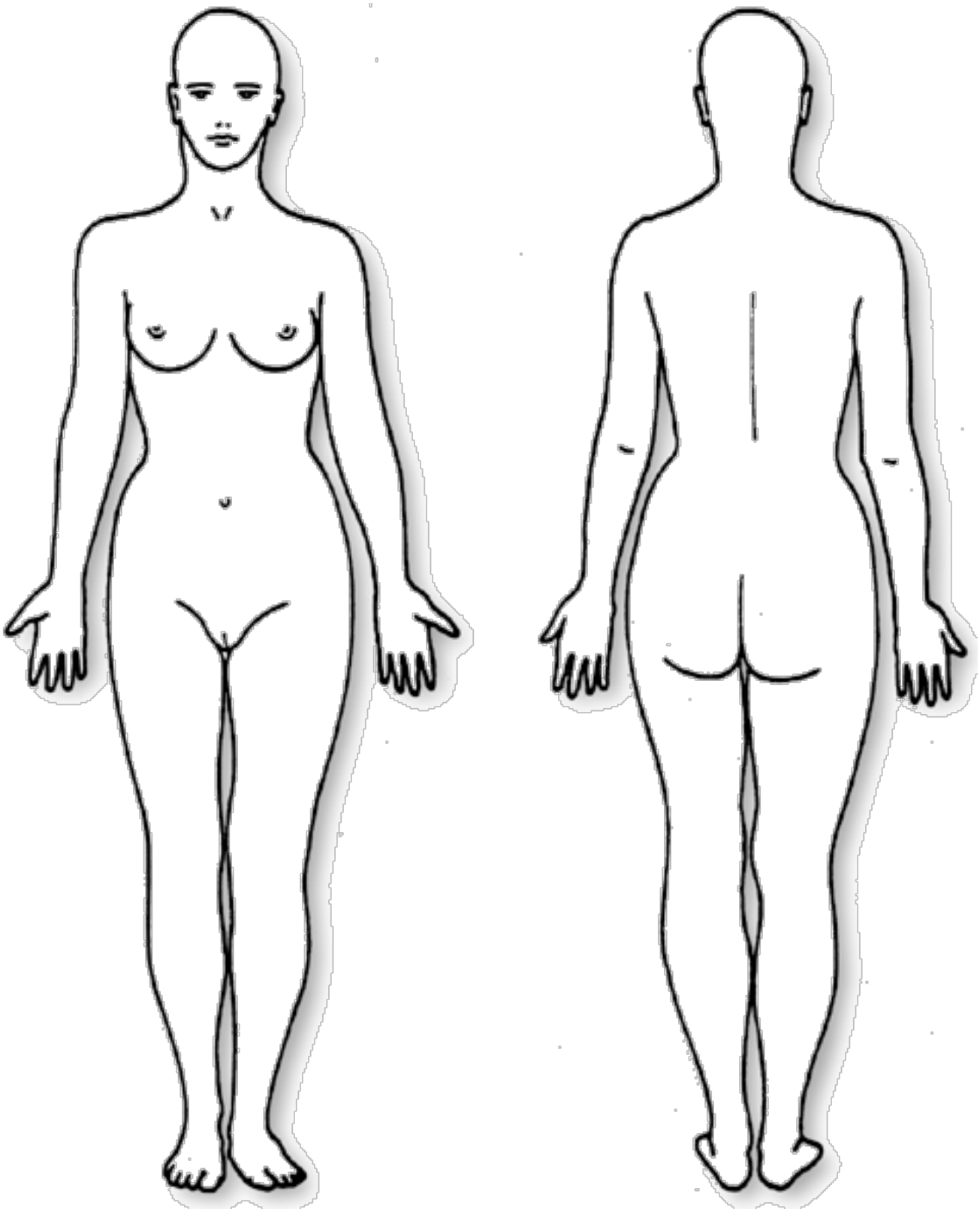
Notes:

- Because there are different words for the same body part, it is a good idea to have a couple different words in the deck of sticky notes.
- The bodies should be gender specific.

BODY DIAGRAM - MALE



BODY DIAGRAM - FEMALE



Myth vs. Fact

GOAL **To show the child myths and facts about sexual offenders/sex.**

EXERCISE

What you need

- Two separate groups of index cards. The first group will be all of the myths. The second group will contain all of the facts related to the myths.
- Myth vs. Fact sheet (to make the cards with)

What you do

- Tell the child you will be playing a game about myths and facts with regards to sexual offenders and sex education, in general.
- Put a myth card and a fact card next to each other.
- Have the child tell you which is the myth and which is the fact.
- Take turns until all cards have been gone through.

Another way to play the game

- Have the child pick a card from the myth pile.
- Have the child tell you the fact that goes with that myth.
- Have the child go through the fact pile and find it.
- Continue taking turns until all cards have been gone through.

Another way to play the game

- Have all of the index cards mixed together.
- Have the child pick one card and tell you if it is a myth or a fact.
- Continue taking turns until all cards have been gone through.

MYTHS VS. FACTS SHEET	
MYTHS	**FACTS**
When a person commits a rape, he/she is really just interested in sex.	Rape is about power and control, not about sex.
If someone was raped, they must have been asking for it.	Nobody ever asks or deserves to be raped
Persons who dress or act in a "sexy" way are asking to be sexually assaulted.	Many convicted sexual assailants are unable to remember what their victims looked like or were wearing. Nothing a person does or does not do causes a brutal crime like sexual assault.
As long as children remember to stay away from strangers, they are in no danger of being assaulted.	Sadly, children are usually assaulted by acquaintances; a family member or other caretaking adult.
Condoms are not very effective in preventing pregnancy and STI.	Repeated studies show that condoms used consistently and correctly offer a high degree (98%) of protection against pregnancy and STI and HIV.
All sex offenders are male.	The vast majority of sex offenders are male. However, females also commit sexual crimes.
Children who are sexually assaulted will sexually assault others when they grow up.	Most sex offenders were not sexually assaulted as children and most children who are sexually assaulted do not sexually assault others.
Children provoke and seduce adults into having sex with them.	Children are innocent and vulnerable. They have little knowledge of sex and of adult sexuality and can in no way be held responsible for adult's responses.
Incest/child sexual abuse only happens to 'bad' girls; look at her behavior; she's not a very nice type.	Incest/child sexual abuse can happen to anyone.
You can't get pregnant if you have sex when you're (or the girl is) having your (her) period.	It's not likely for most women, but it can happen. It is possible for a woman to get pregnant from intercourse during her period, especially if her menstrual cycle is brief or irregular.
A girl can't get pregnant the first time you have sex	If you are having unprotected sex, a girl can get pregnant — whether it is the first time or the one hundred and first time!
Touching your own private parts is not normal.	Touching your private parts for pleasure is completely normal but should be done in privacy.

Sexual Behavior in Children

Caregiver Information Sheet

Sexual development is an important part of a child's development beginning in infancy and continuing into adulthood.

Throughout childhood, children engage in a variety of sexual behaviors which are part of normal, healthy development. Below is a list of some common behaviors exhibited by children during different developmental stages.

Children Birth to 2 Years...

- Begin to explore their bodies, including their genitals;
- Derive pleasurable sensations from genital stimulation;
- Experience penile erections and vaginal lubrication;
- May touch others' genitals;
- May enjoy being nude and undressing in front of others;
- Begin to learn names for body parts, sometimes including genitals.

Children 2 to 6 Years...

- May use slang or correct terms for genital parts;
- May derive pleasurable sensations by touching their genitals;
- May experience orgasm;
- Learn to identify themselves and others by gender;
- Express curiosity about differences between males and females which may lead to exploration with peers;
- May engage in sexual curiosity play with same-age peers and/or siblings involving undressing, looking at, and touching each others' genitals;
- May enjoy undressing and catching others undressing;
- May express love feelings (e.g., wanting to play boyfriend/girlfriend or husband/wife) for caregivers or close relatives.

Children 6 to 12 Years...

- Begin to show increased modesty;
- May continue to masturbate, but will more likely masturbate in privacy;
- May demonstrate increased knowledge of sexual behavior, including masturbation and intercourse;
- May demonstrate understanding of sex as it relates to pregnancy;

Cont.

- May engage in sex games with peers and siblings which may become more secretive and increase in sophistication, including kissing, mutual masturbation, and “playing doctor”;
- May demonstrate increased use of sexual language;
- May demonstrate increased interest in sexually explicit pictures, television, etc.;
- May begin to experience early pubertal changes.

While the behaviors described above are generally considered reflections of normal healthy sexual development, some childhood sexual behaviors raise appropriate concern and may stem from abusive experiences or inappropriate exposure to adult sexuality. The list below describes behaviors that raise concern and are generally considered problematic for children ages 2 to 12 years.

- Age-inappropriate knowledge of adult sexual behavior;
- Obsessive focus on sex-related issues which interferes with child’s participation in developmentally appropriate activities;
- Sex play between children of significantly different ages or sizes;
- Sex play that involves coercion or force;
- Insertion of objects into the vagina or anus;
- Masturbation involving objects;
- Masturbation that is compulsive or public in nature;
- Attempts to put mouth on sex parts;
- Requests to engage in adult sexual acts;
- Inserting tongue in mouth or other people.

While these sexual behaviors are often quite troubling to caregivers, it is important to remember that they are essentially learned behaviors which children can unlearn. Children exhibiting age inappropriate sexual behavior can learn more appropriate means of expressing their emerging sexuality. In fact, it is usually best to respond to inappropriate sexual behaviors much the way we respond to other problem behaviors. First, it is important to communicate clearly and openly about which sexual behaviors are “okay” and which are “not okay.” Next, it is important to encourage appropriate affectionate behavior by modeling and praising behaviors such as hugging, kissing, holding hands, giving “high fives,” sitting with arms around one another and saying “I love you.” Finally, caregivers should establish negative consequences for exhibiting inappropriate sexual behaviors that can be administered in a calm, clear, consistent manner. Since it is often difficult for caregivers to respond effectively to children’s inappropriate sexual behaviors, professional consultation is generally recommended to help caregivers respond most effectively to problematic sexual behaviors.

Children 13 to 18 Years...

- Increase in sexual feelings towards same or opposite sex;
- Increased understanding of the sexual self;
- Same or opposite sex exploration;
- Establishing dating relationships;
- Increased engagement in sexual activity;

Adapted from Deblinger and Stauffer (2004) UMDNJ-SOM CARES Institute

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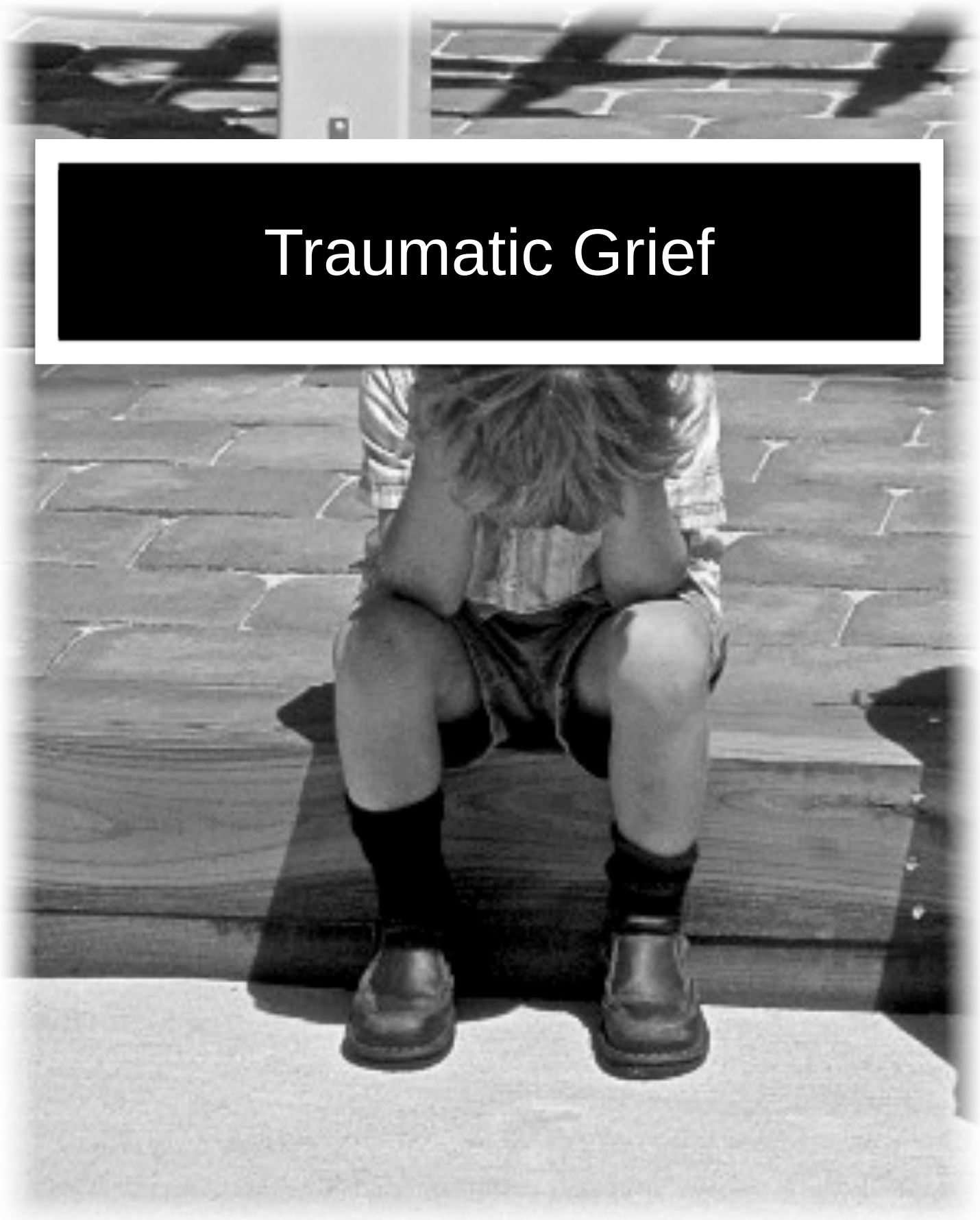
Traumatic Grief



Talking about Death: Common Terms to Use and to Avoid

A Handout for Caregivers

Children hear lots of things about death. They also read about it and are exposed to death on television, in movies, and in video games. The messages can be confusing and even inaccurate. For example, a cartoon character may die and return to life multiple times during an episode. Younger children in particular do not understand that when people die they cannot spring back to life. In addition, adults naturally wish to protect children from death and so they avoid using the words “death,” “dying,” or “dead.” This can add to a child’s misunderstanding.

Caregivers should be honest and direct with children when talking about death. It is best to use simple but correct words that are accurate and right for the child’s age. It can be helpful for the child to hear that the person is no longer physically present and cannot come back home. What the child is told about the cause of the death will vary according to the reason but saying the words “death” or “died” is best. Certainly religious explanations can be part of any discussion that includes these main concepts.

Examples of some common phrases to consider:

- Daddy died and cannot be with us anymore.
- Now that your brother died he can’t breathe or eat anymore. We can’t see him but we can remember him.
- People die when they are very sick and there isn’t any more medicine to help them.
- Grandma died and went to heaven - a place we can’t visit until we die.

It is important to make clear that people who are alive cannot go to heaven and those who are dead cannot come back so children don’t confuse heaven with a place on earth. Families need to balance the explanation based on their beliefs, with an understanding of possible alternative/misunderstood meanings. For example, children may become

confused with the explanation, “Daddy is an angel now, he’s watching over us from heaven” - children may feel he is still alive, that heaven is a place to visit, and that he sees everything they do.

Adults are not always aware of how children attach concrete or inaccurate meaning to different words, so caregivers should avoid using slang. For example, a father explained to his 4-year-old son that “Mommy went to God’s house.” Whenever they walked by a church the boy entered and said he was “looking for mommy in God’s house.” Even saying, “we lost grandpa,” can be upsetting as it can imply that he was not taken care of and misplaced or could still be found.

Examples of common phrases to avoid:

- Daddy went to sleep.
- Your sister went on a long trip.
- He bought the farm.
- He gave up the ghost.
- She cashed in all of her chips.
- She kicked the bucket.
- He’s pushing up daises.
- Grandpa went to the big ranch in the sky.

Traumatic Grief vs. Normal Grieving

A Handout for Professionals

Not all children who experience the death of a loved one will develop childhood traumatic grief. Some children will be able to grieve the loss without complications. A small number of grieving children may develop some reactions or symptoms that can become difficult and perhaps interfere with their daily functioning. Signs that a child is having difficulty coping with the death may be noticeable in the first month or two or may not be apparent until years later. Some of these signs include the following:

- **Intrusive memories about the death:** These can be expressed by nightmares, guilt, or self-blame about how the person died, or recurrent or disturbing thoughts about the terrible way someone died.

- **Avoidance and numbing:** These can be expressed by withdrawal, acting as if not upset, or avoiding reminders of the person, the way he or she died, or the things that led to the death.

- **Physical or emotional symptoms of increased arousal:** Children may show this by their irritability, anger, trouble sleeping, decreased concentration, drop in grades, stomachaches, headaches, increased vigilance, and/or fears about safety for oneself or others.

Normal Grieving	Complicated Grief
The child accepts the reality and permanence of death.	The child has difficulty accepting the death due to its association with the traumatic circumstance.
The child experiences and copes with difficult emotional reactions.	The child experiences intense, distressing feelings that are triggered by reminders of the death – resulting in avoidance or a lack of feelings.
The child adjusts to changes in his life and identity that result from the death.	The child has changes that lead to unpleasant reminders of the way the person died, over-identification with the person who died, or feelings of self-blame.
The child develops new relationships that deepen existing ones.	The child has feelings such as guilt, anger, and revenge that interfere with the formation of new relationships.
The child maintains a continuing healthy attachment to the deceased person through remembrance activities.	The child has difficulty experiencing or avoids positive memories because they are linked to horrible images and upsetting thoughts and feelings.
The child finds some meaning in the death and learns about life or oneself.	The child shows an inability or resistance to move past the terrifying, unpleasant aspects of the death and may have negative feelings about herself related to the death.
The child continues through the normal developmental stages.	The child experiences emotional reactions that interfere with his ability to engage in positive, age-appropriate activities and relationships.

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Vicarious Trauma

Vicarious Trauma: A Hazard of the Helping Professions

Those of us who work with clients who have experienced trauma regularly witness pain and listen to stories that may be difficult to comprehend. What is more, we have been trained to listen intently, to offer empathy and support, and to validate our clients' feelings and experiences. We go deep.

If you work with trauma, it is important for you to understand that it will affect you. That is normal. Some days you will go home carrying with you your clients' feelings of hopelessness, pain, or fear. As you walk through their traumatic experiences with them, you may feel angry, horrified, sickened, or sad.

You know how important it is to help clients cope with whatever feelings they are having. That goes for you too. A crucial part of our work must be to take care of ourselves. If we do not take care of ourselves, we will not have the resources to help our clients.

Pay attention to the warning signs of vicarious trauma, or so-called "compassion fatigue." These include the symptoms you have noted in your clients: nightmares, exhaustion, insomnia, hypervigilence, or playing a scene or narrative over and over in your head. If you are strongly affected at any time, seek help from your supervisor or a colleague. You may need some counseling yourself - and this, too, is normal.

To help avoid developing these symptoms, take time to engage in activities that offer peace and renewal to you. There is no one activity that works for everyone. You will have to make your own list. However, here are a few ideas to get you started:

cont.

- Listen to your favorite soothing music.
- Take a warm bath with pleasant aromas and candles.
- Practice meditation.
- Go for a walk in nature.
- Spend time with close friends.
- Prepare a really good meal and share it with someone.
- Write in a journal.
- Make something: build a birdhouse, knit a sweater, paint a portrait.
- Play with your pet or visit a pet store.
- Work in a garden or with houseplants.
- Watch a funny movie.
- Go camping or fishing.
- Play a musical instrument.
- Read a good book.
- Leaf through silly magazines.
- Practice Yoga or go to the gym.
- Participate in faith-related activities.
- Spend time with your kids.

Your personal Favorites:

Preventing Burnout

If you recognize the warning signs of impending burnout, remember that it will only get worse if you leave it alone. If you take steps to get your life back into balance, you can prevent burnout from becoming a full-blown breakdown.

Burnout Prevention Tips:

Start the day with a relaxing ritual. **Rather than jumping out of bed as soon as you wake up, spend at least 15 minutes meditating, writing in your journal, doing gentle stretches, or reading something that inspires you.**

Adopt healthy eating, exercising, and sleeping habits. **When you eat right, engage in regular physical activity, and get plenty of rest, you have the energy and resilience to deal with life's hassles and demands.**

Set boundaries. **Do not overextend yourself. Learn how to say "no" to requests on your time. If you find this difficult, remind yourself that saying "no" allows you to say "yes" to the things that you truly want to do.**

Take a daily break from technology. **Set a time each day when you completely disconnect. Put away your laptop, turn off your phone, and stop checking e-mail.**

Nourish your creative side. **Creativity is a powerful antidote to burnout. Try something new, start a fun project, or resume a favorite hobby. Choose activities that have nothing to do with work.**

Learn how to manage stress. **When you're on the road to burnout, you may feel helpless - but you have a lot more control over stress than you may think. Learning how to manage stress can help you to regain your balance.**

Preventing Vicarious Trauma: What Counselors Should Know When Working With Trauma Survivors

Robyn L. Trippany, Victoria E. White Kress, and S. Allen Wilcoxon

Counselors in all settings work with clients who are survivors of trauma. Vicarious trauma, or counselors developing trauma reactions secondary to exposure to clients' traumatic experiences, is not uncommon. The purpose of this article is to describe vicarious trauma and summarize the recent research literature related to this construct. The Constructivist Self-Development Theory (CSDT) is applied to vicarious trauma, and the implications CSDT has for counselors in preventing and managing vicarious trauma are explored.

Counselors in virtually all settings work with clients who are survivors of trauma. Trauma can generally be defined as an exposure to a situation in which a person is confronted with an event that involves actual or threatened death or serious injury, or a threat to self or others' physical well-being (American Psychiatric Association, 2000). Client traumas frequently encountered in clinical practice include childhood sexual abuse; physical or sexual assault; natural disasters, such as earthquakes or tornadoes; domestic violence; and school and work-related violence (James & Gilliland, 2001). Many American counselors have recently been faced with a new population of traumatized clients secondary to the recent terrorist attacks on the United States. With estimates indicating that 1 in 6 women (Ratna & Mukergee, 1998) and 1 in 10 men will experience sexual abuse during childhood, and FBI estimates indicating that 1 in 4 women will be victims of sexual assault in their lifetime (Heppner et al., 1995), sexual victimization is one of the most commonly presented client traumas. Clients' reactions to traumas are typically intense fear, helplessness, or horror. As a result of the trauma, the person may experience severe anxiety or arousal that was not present prior to the trauma (American Psychiatric Association, 2000).

Counselors' reactions to client traumas have historically been characterized as forms of either burnout or countertransference (Figley, 1995). More recently, the term *vicarious trauma* (VT; McCann & Pearlman, 1990) has been used to describe counselors' trauma reactions that are secondary to their exposure to clients' traumatic experiences. The construct of VT provides a more complex and sophisticated explanation of counselors' reactions to client trauma and has implications for preventing counselors' VT reactions.

VT has been referred to as involving "profound changes in the core aspects of the therapist's self" (Pearlman & Saakvitne, 1995b, p. 152). These changes involve disruptions in the cognitive schemas of counselors' identity, memory system, and belief system. VT has been conceptualized as being exacerbated by, and perhaps even rooted in, the open engagement of empathy, or the connection, with the client that is inherent in counseling relationships (Pearlman & Saakvitne, 1995b). VT reflects exposure of counselors to clients' traumatic material and encompasses the subsequent cognitive disruptions experienced by counselors (Figley, 1995; McCann & Pearlman, 1990). These repeated exposures to clients' traumatic experiences could cause a shift in the way that trauma counselors perceive themselves, others, and the world. These shifts in the cognitive schemas of counselors can have devastating effects on their personal and professional lives. By listening to explicit details of clients' traumatic experiences during counseling sessions, counselors become witness to the traumatic realties that many clients experience (Pearlman & Mac Ian, 1995), and this exposure can lead to a transformation within the psychological functioning of counselors.

This article describes VT and how it differs from counselor burnout and countertransference. In addition, this article applies the Constructivist Self-Development Theory (CSDT) to VT, and discusses the implications CSDT has for preventing and managing counselor VT.

VT, BURNOUT, AND COUNTERTRANSFERENCE

Previously, in the professional literature, the term VT was not used; such trauma was referred to as being either a form of burnout or a countertransference reaction (Figley, 1995; McCann & Pearlman, 1990). Recently, differences among the concepts of burnout, countertransference, and VT have been identified. There are several significant differences between burnout and VT. Burnout is described more as a result of the general psychological stress of working with difficult clients

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hopeless, and outraged (Herman, 1992; Pearlman & Saakvitne, 1995a). "The defenses employed to protect oneself from knowledge of people's capacity for cruelty . . . have their own costs" (Pearlman & Saakvitne, 1995a, p. 288). These defenses, produced from changes in cognitive schemas regarding one's view of the world (i.e., the world is good; people are good), create a reorganization in the counselor's spirituality. As a result, the counselor may experience sorrow, confusion, and despair.

Research indicates that counselors with a "larger sense of meaning and connection" (Pearlman & Saakvitne, 1995b, p. 161) are less likely to experience VT. In a survey of trauma counselors, 44% reported that spirituality provided an effective coping mechanism in dealing with the effects of their work (Pearlman & Mac Ian, 1993). Finding meaning can help trauma counselors alleviate the impact of VT. Astin (1997) reported that working with rape victims has made her more aware of the potential for harm, thus making her more prudent. She wrote, "My rape clients have given me a gift without knowing it . . . I don't live in a fantasy world and I take active steps to reduce risk and vulnerability" (Astin, 1997, p. 107). In addition, Wittine (1995) suggested that counselors with a strong sense of spirituality are more likely to accept existential realities and their inability to change the occurrence of these realities. Wittine further suggested that counselors' acceptance of these existential realities allows them to be more present with their clients.

More specifically, counselors who are at risk for developing VT can use whatever source brings them a sense of spirituality. Organized religions, meditation, and volunteer work are just a few examples of activities that may facilitate a sense of spirituality. Ultimately, it is up to the individual counselor to determine how he or she will choose to develop his or her sense of spirituality.

CONCLUSION

Vicarious traumatization is a significant concern for counselors providing services to traumatized clients. Counselors' cognizance of potential changes in their beliefs about self, others, and the world may have a preventative function regarding VT. This awareness can aid counselors in protecting themselves against the consequential effects of helping those with traumatic histories. An awareness of personal reactions to VT may allow counselors to implement self-care strategies to ameliorate such effects, thus minimizing potential ethical and interpersonal difficulties.

In addition, it is important that supervisors and administrators overseeing counselors working with trauma survivors consider the impact that VT may have on counselors and take an active preventative role. Supervisors have a responsibility to use their knowledge about VT to prevent counselor VT and to facilitate counselor mental health through providing a supportive and VT-preventative environment. Encouraging peer support groups, educating counselors on the impact of client traumas on counselors, diversifying counselor caseloads, encouraging counselor respite and relaxation, and encouraging counselors' sense of spirituality and wellness are several means of providing support for at-risk counselors. Professional counselors have many strengths and resources that are used to help traumatized clients—applying these resources to themselves, as a means of preventing VT, will surely facilitate their own wellness.

REFERENCES

Alpert, J. L., & Paulson, A. (1990). Graduate-level education and training in child sexual abuse. *Professional Psychology: Research and Practice, 21,* 366–371.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Astin, M. C. (1997). Traumatic therapy: How helping rape victims affects me as a therapist. In M. Hill (Ed.), *More than a mirror: How clients influence therapists' lives* (pp. 101–109). Binghamton, NY: Haworth.

Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1997). Vicarious traumatization, spirituality and the treatment of adult and child survivors of sexual abuse: A national survey of women psychotherapists. *Professional Psychology: Research and Practice, 30,* 386–393.

Catherall, D. R. (1995). Coping with secondary traumatic stress: The importance of the therapist's professional peer group. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 80–94). Lutherville, MD: Sidran.

Chrestman, K. R. (1995). Secondary exposure to trauma and self-reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 29–36). Lutherville, MD: Sidran.

Cunningham, M. (1999). The impact of sexual abuse treatment on the social work clinician. *Child and Adolescent Social Work Journal, 16,* 277–290.

Dyregrov, A., & Mitchell, J. T. (1996). Work with traumatized children: Psychological effects and coping strategies. *Journal of Traumatic Stress, 5,* 5–17.

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3–28). Lutherville, MD: Sidran.

Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice, 25,* 275–282.

Hellman, I. D., Morrison, T. L., & Abramowitz, S. I. (1987). Therapist experience and the stresses of psychotherapeutic work. *Psychotherapy, 24,* 171–177.

Heppner, M. J., Good, G. E., Hillenbrand-Gunn, T. L., Hawkins, A. K., Hacquard, L. L., Nichols, R. K., et al. (1995). Examining sex differences in altering attitudes about rape: A test of the elaboration likelihood model. *Journal of Counseling & Development, 73,* 640–747.

Herman, J. L. (1992). *Trauma and recovery.* New York: Basic Books.

James, R. K., & Gilliland, B. E. (2001). *Crisis intervention strategies* (4th ed.). Belmont, CA: Brooks/Cole.

Kassan-Adams, N. (1995). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 37–48). Lutherville, MD: Sidran.

Lyon, E. (1993). Hospital staff reactions to accounts by survivors of childhood abuse. *American Journal of Orthopsychiatry, 63,* 410–416.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* 131–149.

McCann, I. L., & Pearlman, L. A. (1992). Constructivist self-development theory: A theoretical model of psychological adaptation to severe trauma. In D. K. Sakheim & S. E. Devine (Eds.), *Out of darkness: Exploring satanism and ritual abuse* (pp. 185–206). New York: Lexington.

Munroe, J. F. (1995). Ethical issues associated with secondary trauma in therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 211–229). Lutherville, MD: Sidran Press.

an average of 14 to 15 clients per week did not have statistically significant experiences of VT. This finding suggests that the management of counselors' caseloads through limiting the number of trauma clients per week may minimize the potential vicarious effects of working with traumatized clients. This implication is consistent with the research of Hellman, Morrison, and Abramowitz (1987), who reported that counselors indicated less work-related stress with a moderate number of clients on a weekly caseload than with a higher number of regularly scheduled clients.

Peer Supervision

Peer supervision groups serve as important resources for trauma counselors (Catherall, 1995). Sharing experiences of VT with other trauma counselors offers social support and normalization of VT experiences. This normalization lessens the impact of VT, which in turn amends cognitive distortions and helps counselors maintain objectivity. Other benefits include reconnecting with others and sharing potential coping resources (Catherall, 1995). Pearlman and Mac Ian (1993) found that 85% of trauma counselors reported discussion with colleagues as their most common method of dealing with VT. Peer supervision methods are helpful in providing trauma counselors with validation and support, in providing them with the opportunity to share new information related to therapeutic work, and in allowing them to vent their feelings (Oliveri & Waterman, 1993). Talking to colleagues about their experience in responding to trauma offers trauma workers support in dealing with aftereffects (Dyregrov & Mitchell, 1996). Peer supervision has also been found to decrease feelings of isolation and increase counselor objectivity, empathy, and compassion (Lyon, 1993).

Peer supervision offers several benefits to trauma counselors. First, consultation with colleagues provides an opportunity for counselors to examine their perspective, thus aiding in decreasing cognitive disruptions. Peer supervision also gives counselors an opportunity to debrief and express reactions regarding client stories (Catherall, 1995). Whereas limits of confidentiality prevent counselors from being able to debrief with support systems, peer supervision serves as a medium for counselors to debrief in an ethical manner. Furthermore, supervision helps alleviate issues of countertransference and traumatic reactions (Rosenbloom et al., 1995). "It is important for caregivers to have a variety of peer support resources to allow easy access to share with others the burden of bearing witness to traumatic events" (Yassen, 1995, p. 194). Discussion of therapeutic successes in formal peer supervision helps to reaffirm a counselor's confidence in his or her clinical skills (Pearlman & Saakvitne, 1995b).

Agency Responsibility

Agencies that employ counselors who provide services to clients with traumatic histories have a responsibility to help their clinicians decrease the effects or occurrence of VT (Pearlman & Saakvitne, 1995b). Formal measures of informed consent regarding risks of providing trauma counseling services can be used as a standard employment procedure when considering new counselors. In addition, professional development resources should be available for trauma counselors, including (a) opportunities for supervision, (b) consultation, (c) staffing, and (d) continuing education. Pearlman and Saakvitne (1995b) further suggested that provision of employee benefits could decrease the impact of VT, including (a) insurance for personal counseling, (b) paid vacations, and (c) limiting the number of trauma survivors on the counselor's caseload. In addition, Chrestman (1995) found empirical evidence suggesting that increased income correlated positively with a decrease in symptoms of psychological distress. Thus, pay raises may help trauma counselors acknowledge success as a counselor.

Education and Training

Training focused on "traumatology" is vital for trauma counselors and can decrease the impact of VT (Pearlman & Saakvitne, 1995b). In a study by Follette, Polusny, and Milbeck (1994), 96% of mental health professionals reported that education regarding sexual abuse was imperative to effective coping with difficult client cases. Chrestman (1995) also found empirical evidence that supported use of additional training to decrease the symptomatology of posttraumatic stress disorder in counselors working with trauma clients. Furthermore, Alpert and Paulson (1990) suggested that graduate programs for mental health professionals need to incorporate training regarding the impact of clients' childhood trauma and its effects on VT.

Personal Coping Mechanisms

The impact of VT can be decreased when counselors maintain a balance of work, play, and rest (Pearlman, 1995). This balance includes socializing with friends and family, being involved in creative activities, and being physically active. Participation in the aforementioned activities may aid in preserving a sense of personal identity. Because of their restorative nature, rest and leisure activities (e.g., taking vacations) are important in decreasing the effects of VT (Pearlman, 1995). Moreover, VT may affect counselors' ability to trust others; therefore, a strong social support network can help to prevent VT and may also help soothe VT reactions. In addition, participation in activities that increase counselors' personal tolerance level, including journaling, personal counseling, meditation, and obtaining emotional support from significant others, allows reconnection to emotions.

Spirituality

The damage of vicarious traumatization is often related to the counselor's sense of spirituality (Pearlman & Saakvitne, 1995a). The VT experience results in a loss of a sense of meaning and often fractures cognitive schemas and counselors' worldview. Without a sense of meaning, counselors may become cynical, nihilistic, withdrawn, emotionally numb,

Control Needs

Control needs are related to self-management; when schemas are disrupted regarding sense of control, the resulting beliefs and behaviors may be helplessness and/or overcontrol in other areas. "These beliefs lead to distress as we [counselors] question our ability to take charge of our lives, to direct our future, to express our feelings, to act freely in the world" (Pearlman & Saakvitne, 1995a, p. 292).

The memory system of each individual is basic to his or her perception of life. Pearlman and Saakvitne (1995a) identified five aspects of the memory system: (a) verbal memory (cognitive narrative), (b) imagery (pictures stored in the mind), (c) affect (emotions experienced), (d) bodily memory (physical sensations), and (e) interpersonal memory (resulting dynamics in current interpersonal relationships). With traumatic experiences, each aspect of memory can represent a fragment of a traumatic event. Without therapeutic integration of these aspects, the fragments interfere with one's awareness and perception. Therefore, through empathic engagement with the client, the counselor is vulnerable to experiencing VT and intrusion from clients' descriptions of memories.

These recollections can remain with the counselor long after the therapy session has ended, even to the point of introducing thoughts and images that involve the counselor having nightmares of being raped. Astin (1997) wrote that she would imagine a rapist coming toward her—much as the rapist had approached the victimized client. The author suggested that intrusive images are associated with normal perceptual processing for traumatic events but, due to the painful emotions involved, resist assimilation into memory as simple events to become actual mental representations. To combat these intrusive thoughts and images, the counselor may turn to numbing, avoidance, and denial. However, avoidance and numbing provide only temporary relief. Astin further suggested that these intrusive images need to be examined, rather than suppressed or overshadowed, to make them less painful and intrusive for the counselor.

PROFESSIONAL AND PERSONAL CONSEQUENCES OF VT

Constructivist self-development theory and recent research suggest that the experience of VT is significant for counselors on both a personal and professional level. A concern for the personal functioning of trauma counselors is the increased awareness of the reality and occurrence of traumatic events. This reality makes counselors more aware of their vulnerability. Safety and security are threatened when counselors become cognizant of the frequency of trauma, often resulting in a loss of feeling in control as a result of hearing clients' stories in which the control was taken from them. In addition, the helplessness of a counselor to change past trauma can challenge, or even shatter, the counselor's identity (Pearlman & Saakvitne, 1995b).

VT can also affect how counselors relate to their friends and family. Counselors affected by VT may be less emotionally accessible due to a decrease in access to emotions (Saakvitne & Pearlman, 1996). Intimacy with partners may become difficult as guilt and intrusive thoughts related to a client's abuse become present when engaging in intimacy. Counselors may also experience overwhelming grief, which may create a sense of alienation from others (Herman, 1992). Herman reported that counselors who worked with survivors of the Nazi Holocaust reported feeling "engulfed in anguish" or "sinking into despair" (p. 144). Finally, the counselor may experience changes in esteem for self and others (Saakvitne & Pearlman, 1996).

The impact of VT on counselors, if unacknowledged, can present ethical concerns (Saakvitne & Pearlman, 1996). The potential for clinical error and therapeutic impasse increases as the vulnerability that counselors experience increases. The disruptions in cognitive schemas may lead to counselors compromising therapeutic boundaries (e.g., forgotten appointments, unreturned phone calls, inappropriate contact, abandonment, and sexual or emotional abuse of clients). Counselors may feel anger toward their clients when they have not complied with some idealized response to therapy (Herman, 1992). Counselors may begin doubting their skill and knowledge and potentially lose focus on clients' strengths and resources (Herman, 1992). In addition, counselors may avoid discussion of traumatic material or be intrusive when exploring traumatic memories by probing for specific details of the client's abuse or pushing to identify or confront perpetrators before the client is ready (Munroe, 1995).

Other hazards the client may be subjected to when the counselor is experiencing VT include irritability of the counselor, decreased ability to attend to external stimuli, misdiagnosis, and "rescuing" by the counselor (Munroe, 1995). In addition, the client may attempt to protect the counselor, which may create an ethical bind based on exploitation of the client. Any of these effects can be damaging to the client. Therefore, addressing the occurrence of VT is imperative for counselors.

IMPLICATIONS FOR COUNSELORS: PREVENTING VT

CSDT as applied to VT has numerous implications for counselors who work with traumatized clients and are thus at risk for VT. Being aware of the risk of VT and applying the CSDT model to one's experiences may prevent VT. More specifically, counselors can apply the CSDT model to their own experiences, thus preventing negative professional and personal consequences and encouraging self-care. The following sections describe ways that counselors can engage in the prevention of VT through self-care.

Caseload

Counselors who work primarily with trauma survivors experience a greater measure of VT than counselors with a general caseload who may see only a few trauma survivors (Brady, Guy, Poelstra, & Brokaw, 1997; Chrestman, 1995; Cunningham, 1999; Kassan-Adams, 1995; Pearlman & Mac Ian, 1993; Schauben & Frazier, 1995). Trippany, Wilcoxon, and Satcher (2003) found that sexual trauma counselors who reported

The frame of reference encompasses one's identity, worldview, and belief system and is the foundation for viewing and understanding the world and self. It also involves cognitive processing of causality and attribution. Any disruptions in an established frame of reference can create disorientation for the counselor and potential difficulties in the therapeutic relationship. For example, in attempting to understand a client's pain, counselors discussing a traumatic event may conclude that the victim was actually to blame, an outcome that will likely revictimize the client. Such an outcome might be the result of the counselor's frame of reference not accommodating the possibility of a blameless victim.

Self-capacities, the second component of CSDT, are "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive self-esteem" (Pearlman & Saakvitne, 1995a, p. 64). These self-capacities allow individuals to manage emotions, sustain positive feelings about themselves, and maintain relationships with others. Self-capacities are susceptible to disruptions when a counselor experiences VT and may result in counselors experiencing a loss of identity, interpersonal difficulties, difficulty controlling negative emotions or avoiding exposure to media that conveys the suffering of others, or feelings of being unable to meet the needs of significant others in their lives. The inability to tolerate negative emotions could have pronounced implications for counselors attempting to serve trauma survivors.

The third component of CSDT, ego resources, allows individuals to meet their psychological needs and relate to others interpersonally (Pearlman & Saakvitne, 1995a). Some of these resources include (a) ability to conceive consequences, (b) ability to set boundaries, and (c) ability to self-protect. Disruptions affecting these ego resources may promote symptoms such as perfectionism and overextension at work. Counselors may also experience an inability to be empathic with clients, a condition that poses a variety of practical and ethical dilemmas, particularly for services to trauma survivors.

The fourth and fifth components of CSDT are psychological needs and cognitive schemas. These include safety needs, trust needs, esteem needs, intimacy needs, and control needs. These needs reflect basic psychological needs of individuals, as well as how individuals process information related to these needs in developing their cognitive schemas about themselves and others (Pearlman & Saakvitne, 1995a). As discussed in this article, these psychological needs can be very helpful in understanding VT and how to prevent VT in counselors. A discussion of each of these aspects and their relationship to VT is reflected in the following sections.

Safety Needs

A sense of security is basic to safety needs. Counselors experiencing VT may feel there is no safe haven to protect them from real or imagined threats to personal safety. According to Pearlman (1995), higher levels of fearfulness, vulnerability, and concern may be ways in which this disruption in safety needs is manifested. Counselors experiencing VT may be overly cautious regarding their children or may feel an overwhelming need to take a self-defense course, install a home alarm system, or carry mace or a rape whistle for protection. The following segment of an interview with a counselor experiencing VT, after working with a sexual trauma survivor, illustrates this point with vivid clarity:

> I suddenly find myself more critical of the quality of locks in my home and replace them with better ones. The car door is always locked when I am driving. I am more careful with whom I speak in public. I find myself wondering why that guy is walking toward me and clutch my keys ready to strike out if I have to. I question the motives of others much more readily and never assume they mean no harm to me. (Astin, 1997, p. 106)

Trust Needs

According to CSDT, trust needs include self-trust and other trust. Trust needs reflect an individual's ability to trust her or his own perceptions and beliefs, as well as to trust others' ability to meet his or her emotional, psychological, and physical needs; in other words, trust needs refer to a form of attachment or a "healthy dependency" (Pearlman & Saakvitne, 1995a, p. 71). All people, according to CSDT, have a natural need to trust themselves and others.

A counselor's inherent trust needs make him or her vulnerable to VT. In other words, the exposure to repeated client trauma shakes the trusting foundations upon which the counselor's world rests. For example, a counselor may have a caseload of clients who were recently exposed to a terrorist act by a minority group and, hence, may have his or her trusting foundation shaken and may become suspicious of all minority group members. This suspiciousness may even transcend previously trustworthy relationships with minority group members. In addition, counselors experiencing VT are vulnerable to self-doubt and inhibited self-trust, often prompting them to question their ability to judge and intervene effectively with clients. Such trust difficulties frequently promote negative effects in relation to esteem needs.

Esteem Needs

The need for esteem is characterized by value for self and value for others (Pearlman, 1995). Counselors experiencing VT may feel inadequate and question their own abilities to help someone. Esteem for others can be compromised as counselors are faced with the ability of people to be cruel and for the world to be unfair.

Intimacy Needs

Intimacy needs are defined as "the need to feel connected to oneself and others" (Pearlman & Saakvitne, 1995a, p. 62). Pearlman (1995) described consequences of disruptions in this area as feelings of emptiness when alone, difficulty enjoying time alone, an intense need to fill alone time, and avoidance and withdrawal from others. VT may cause a counselor to push away or become increasingly dependent on significant persons in his or her life.

(Figley, 1995) versus VT, which is seen as a traumatic reaction to specific client-presented information. Also, vicarious traumatization occurs only among those who work specifically with trauma survivors (e.g., trauma counselors, emergency medical workers, rescue workers, crisis intervention volunteers), whereas burnout may occur in persons in any profession (McCann & Pearlman, 1990). VT and burnout also differ in that burnout is related to a feeling of being overloaded secondary to client problems of chronicity and complexity, whereas VT reactions are related to specific client traumatic experiences. Thus, it is not the difficult population with which the counselor works, but rather the traumatic history of a traumatized population that contributes to VT. Burnout also progresses gradually as a result of emotional exhaustion, whereas VT often has a sudden and abrupt onset of symptoms that may not be detectable at an earlier stage. Finally, on a personal level, burnout does not lead to the changes in trust, feelings of control, issues of intimacy, esteem needs, safety concerns, and intrusive imagery that are foundational to VT (Rosenbloom, Pratt, & Pearlman, 1995). It is important to note that many counselors working with traumatized populations experience general burnout as well as VT.

Despite these contrasts, VT and burnout share similar characteristics. Both VT and burnout may result in physical symptoms, emotional symptoms, behavioral symptoms, work-related issues, and interpersonal problems. In addition, both VT and burnout are responsible for a decrease in concern and esteem for clients, which often leads to a decline in the quality of client care (Raquepaw & Miller, 1989).

Like the construct of burnout, countertransference is also distinct from VT. Countertransference refers to a counselor's emotional reaction to a client as a result of the counselor's personal life experiences (Figley, 1995). VT, however, is a direct reaction to traumatic client material and is not a reaction to past personal life experiences. The differences between countertransference and VT are not always distinct. Although VT may involve countertransference issues (e.g., the counselor being a trauma survivor), VT is not inherent in, nor does it equate to, countertransference (Figley, 1995). An additional difference between countertransference and VT is that countertransference is specific to the counselors' experiences during or around counseling sessions, whereas VT effects transcend the session, thus affecting all aspects of counselors' lives.

Countertransference and VT, although distinct in conceptualization, are related to one another. As a counselor experiences increasing levels of VT, the related disruptions in cognitive schemas become part of the counselor's unconscious personal material that may then result in countertransference reactions toward the client (Saakvitne & Pearlman, 1996). These differences among VT, countertransference, and burnout indicate that VT is a unique construct that is worthy of consideration apart from the concepts of burnout and countertransference. The management and prevention of burnout reactions and countertransference have been addressed in the literature (James & Gilliland, 2001), yet these issues are rarely addressed with regard to VT. Despite VT's apparent importance and uniqueness, there is a paucity of research and literature exploring ways in which counselors working with traumatized clients can prevent VT reactions from developing.

VT AND CSDT

As previously stated, VT has a unique progression. One theory that can be used to explain this progression is the CSDT (McCann & Pearlman, 1992; Pearlman & Saakvitne, 1995a). The premise of this theory is that individuals construct their realities through the development of cognitive schemas or perceptions, which facilitate their understanding of surrounding life experiences. CSDT supports the notion that changes in these cognitive schemas, or the perceived realities of counselors, occur as a result of interactions among clients' stories and counselors' personal characteristics (Saakvitne & Pearlman, 1996). In this self-development process, counselors are active in creating and structuring their individual perceptions and realities. CSDT "emphasizes the adaptive function of individual behavior and beliefs, and the individual's style of affect management" (Pearlman & Saakvitne, 1995a, p. 56), thus indicating that counselors' VT reactions to client-presented traumas are normal and adaptive.

CSDT further purports that human cognitive adaptation occurs in the context of interpersonal, intrapsychic, familial, cultural, and social frameworks. According to CSDT, counselor VT experiences are normal counselor adaptations to recurrent client-presented traumatic material. Essentially, CSDT proposes that irrational perceptions develop as self-protection against these emotionally traumatic experiences. In addition, CSDT suggests that the effects of these changes in counselors' cognitive schemas are pervasive (i.e., have the potential to affect every area of the counselor's life) and cumulative (i.e., potentially permanent because each traumatized client the counselor encounters reinforces these changes in cognitive schemas; McCann & Pearlman, 1990).

According to CSDT, there are five components of the self and how the self and one's perceptions of reality are developed: (a) frame of reference; (b) self-capacities; (c) ego resources; (d) psychological needs; and (e) cognitive schemas, memory, and perception (Pearlman & Saakvitne, 1995a). These CSDT components reflect the areas in which counselors' distorted beliefs and VT reactions occur. Saakvitne and Pearlman (1996) proposed that the interpersonal components of CSDT (i.e., frame of reference, self-capacities, ego resources, psychological needs, and memory system) are the most vulnerable to symptomatic adaptation (e.g., disruptions in previous belief systems as a result of clients' trauma material) in the emergence of VT in counselors.

In discussing the first component of CSDT, frame of reference, McCann and Pearlman (1990) wrote that "a meaningful frame of reference for experience is a fundamental human need" (p. 141). The frame of reference is generally defined as an individual's framework, or context, for understanding and viewing the self and the world (Pearlman & Saakvitne, 1995b).

Oliveri, M. K., & Waterman, J. (1993). Impact on therapists. In J. Waterman, R. J. Kelly, M. K. Oliveri, & J. McCord (Eds.), *Behind the playground walls: Sexual abuse in preschools* (pp. 190–202). New York: Guilford.

Pearlman, L. A. (1995). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 51–64). Lutherville, MD: Sidran.

Pearlman, L. A., & Mac Ian, P. S. (1993). Vicarious traumatization among trauma therapists: Empirical findings on self-care. *Traumatic Stress Points: News for the International Society for Traumatic Stress Studies, 7*(3), 5.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26,* 558–565.

Pearlman, L. A., & Saakvitne, K. W. (1995a). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: Norton.

Pearlman, L. A., & Saakvitne, K. W. (1995b). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150–177). Bristol, PA: Brunner/Mazel.

Raquepaw, J. M., & Miller, R. S. (1989). Psychotherapist burnout: A componential analysis. *Professional Psychology: Research and Practice, 20,* 32–36.

Ratna, L., & Mukergee, S. (1998). The long-term effects of childhood sexual abuse: Rationale for and experience of pharmacotherapy with nefazodone. *International Journal of Psychiatry in Clinical Practice, 2,* 83–95.

Rosenbloom, D. J., Pratt, A. C., & Pearlman, L. A. (1995). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 65–79). Lutherville, MD: Sidran.

Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization.* New York: Norton.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19,* 49–64.

Trippany, R. L., Wilcoxon, S. A., & Satcher, J. F. (2003). Factors influencing vicarious trauma for therapists of survivors of sexual victimization. *Journal of Trauma Practice, 2,* 47–60.

Yassen, J. (1995). Preventing secondary traumatic stress disorder. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 178–208). Bristol, PA: Brunner/Mazel.

Wittine, B. (1995). The spiritual self: Its relevance in the development and daily life of the psychotherapist. In M. B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 288–301). New York: Wiley.

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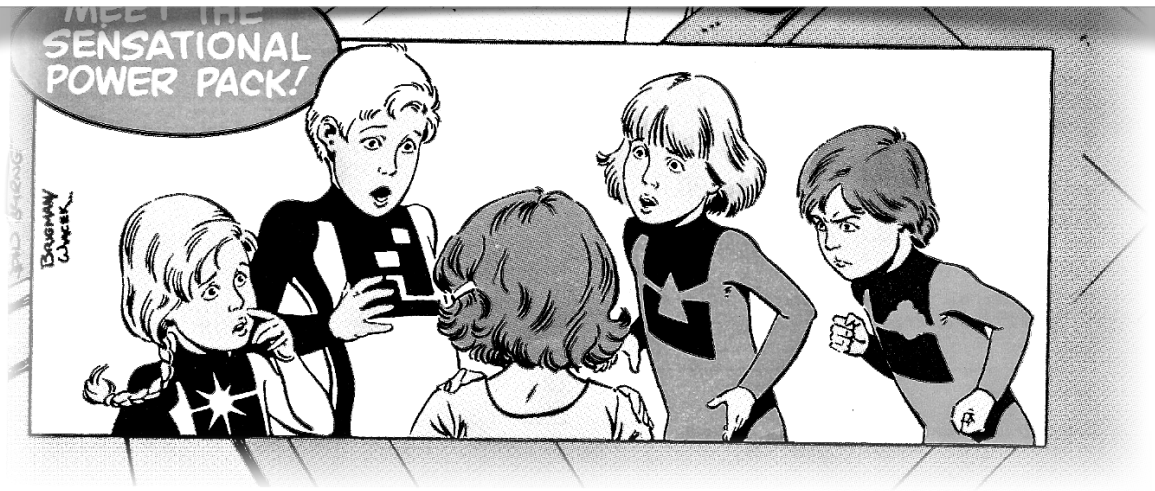
Spider-Man on Sexual Abuse

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Dear Reader:

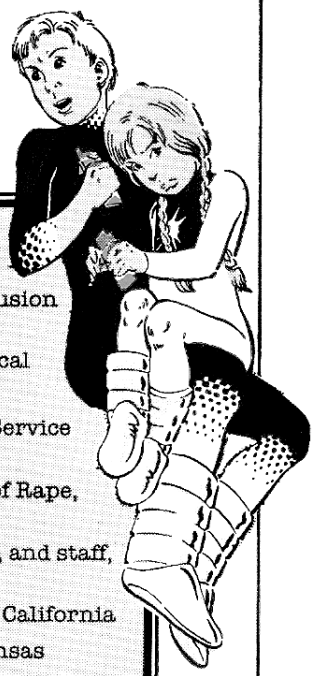
The stories you are about to read may seem familiar to you. They are about children who have been forced or tricked or conned by an older person into touch or sexual contact. This is called child sexual abuse. Perhaps you or someone you know has been sexually abused. If so, you're not alone. Probably over a half million children experience some kind of sexual abuse every year.

The purpose of this book is to teach you how to protect yourself from sexual abuse and what to do if it happens to you. It shows you that even people you know and trust can touch you in ways or in places that feel uncomfortable or yukky or just not right. Or, they can make you touch them in private places. And this book tells you that if this happens, it's not your fault — you can say no — and there is help out there.

Just like Spider-Man and Power Pack, you are not powerless. You can help yourself and you can help others. We hope that you will find this comic book valuable and that you will share it with a friend.

Sincerely,

Anne H. Cohn, D.P.H.
Executive Director
National Committee for Prevention of Child Abuse



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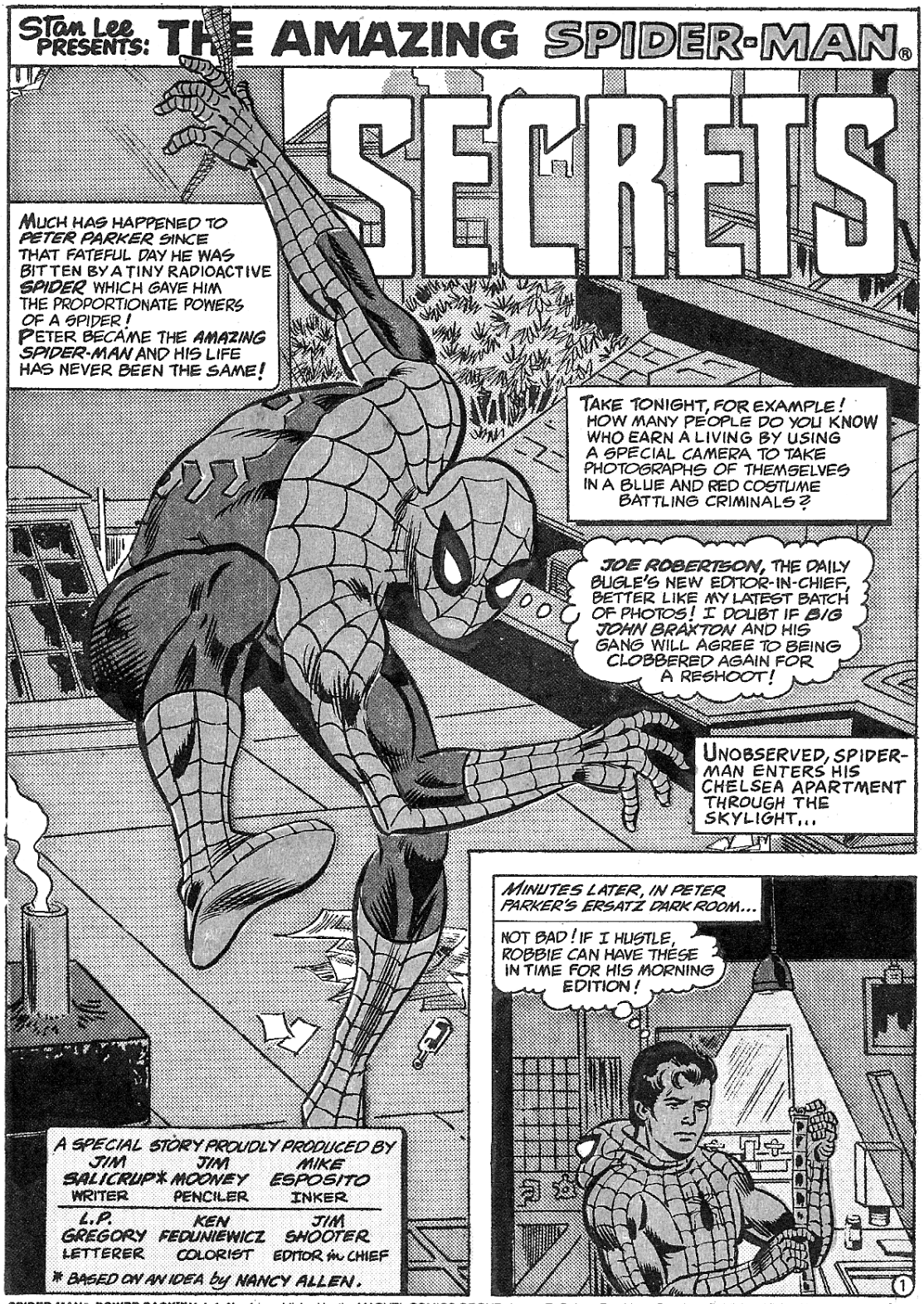

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LEAVE ME ALONE! PLEASE! I DON'T WANT TO DO ANY-THING LIKE THAT!
VOICES! COMING FROM THE APARTMENT NEXT DOOR! SOUNDS LIKE THE LEWIS'S LITTLE BOY TONY!
THANKS TO NEW YORK CITY'S FAMOUS THIN WALLS, I SHOULD BE ABLE TO FIGURE OUT WHAT'S GOING ON!
LISTEN, TONY! WHAT HAPPENED HERE TONIGHT IS OUR LITTLE SECRET! AND YOU BETTER NOT TELL OR I MAY HAVE TO HURT YOU OR GET YOU INTO BIG TROUBLE!
YES, JUDY! SOB!...I UNDER-STAND!
I'VE HEARD ENOUGH!
LIKE A MAN POSSESSED, THE WALL-CRAWLER SWIFTLY TAKES ACTION IN HIS OWN UNIQUE WAY...
TAP! TAP!
HEY, TONY! OPEN UP! IT'S ME, YOUR FRIENDLY NEIGHBORHOOD SPIDER-MAN!
REMEM-BER WHAT I SAID...
COMING HERE AS SPIDER-MAN SERVES MANY PURPOSES! DON'T GO AWAY MAD, JUDY--JUST GO AWAY!
HOPE YOU DON'T MIND ME DROPPING IN!
ARE YOU CRAZY! YOU'RE MY HERO! I THINK YOU'RE THE GREATEST!
2


I'M FLATTERED, TONY! TELL ME, WHO WAS THAT GIRL AND WHAT WAS SHE DOING HERE?
YOU MEAN JUDY! SHE'S JUST MY SITTER! MY MOM AND DAD ARE AT A PARTY ACROSS TOWN AND SHE WAS TAKING CARE OF ME!
I KNOW SOMETHING HAPPENED HERE TONIGHT! THAT'S WHY JUDY RAN AWAY! PLEASE, TONY, DON'T BE AFRAID TO TELL ME--I'M YOUR FRIEND!
JUDY SAID IT WAS A SECRET-- AND THAT SHE'D HURT ME IF I TOLD!
IT SOUNDS TO ME LIKE IT WILL HURT YOU MORE IF YOU DON'T TELL!
AFTER A LONG SILENCE, TONY FINALLY SPEAKS...HIS WORDS CHOKED WITH EMOTION...
...I GUESS I CAN TELL YOU!
Special! NOW! SUDZ SOAP
"I ALWAYS LIKED JUDY! WE'D WATCH TV AND PLAY GAMES DURING THE DUMB OL' COMMERCIALS!
HIYO, JUDY AWAY!
"SHE'D LET ME STAY UP REAL LATE AND WATCH ANY SHOW I WANTED!
"I ASKED JUDY IF I COULD WATCH 'STAR WARS' TONIGHT AND SHE STARTED TICKLING ME...
I'LL LET YOU WATCH YOUR MOVIE ON ONE CONDITION...
HAHA SURE, ANYTHING YOU WANT! HA HA-- JUST STOP!
HERE'S THE DEAL! YOU WANT TO SEE THE MOVIE-- TAKE ALL YOUR CLOTHES OFF!
WHAT?!
3


"I DIDN'T UNDERSTAND WHAT WAS HAPPENING, BUT IT DIDN'T SEEM RIGHT!
WHAT'S THE MATTER? YOU SHY OR SOMETHING?
NO! I'M TIRED--I'M GOING TO BED!
BUT WHAT ABOUT YOUR MOVIE?! WE CAN HAVE LOTS OF FUN--STAYING UP LATE AND PLAYING GROWN-UPS!
LEAVE ME ALONE! PLEASE! I DON'T WANT TO DO ANYTHING LIKE THAT!
AND THEN SHE STARTED TO TOUCH ME. THAT'S WHEN YOU SHOWED UP."
I'M SCARED, SPIDEY! TELL ME, DID I DO SOMETHING WRONG? IS THIS ALL MY FAULT?
DON'T EVEN THINK THAT!
OF COURSE IT'S NOT YOUR FAULT! SHE WAS WRONG TO TOUCH YOU LIKE THAT. AND YOU DID THE RIGHT THING BY TELLING ME!
THIS REMINDS ME OF SOMETHING THAT HAPPENED A LONG TIME AGO...
"...TO A BOY LIKE YOU, EXCEPT HE LIVED WITH HIS AUNT AND UNCLE...
I'VE BAKED A BATCH OF YOUR FAVORITE DOUGHNUTS, DEAR! RUN ALONG AND WASH UP!
BETTER HURRY! YOUR AUNT'S DOUGHNUTS ARE SO TASTY, I MAY EAT THEM ALL MYSELF!
THEY SMELL SO GOOD I CAN HARDLY WAIT!
"TO MAKE HIS AUNT AND UNCLE HAPPY, THE BOY STUDIED VERY HARD AND DIDN'T HAVE MUCH TIME FOR SPORTS...
THAT HISTORY QUIZ TODAY IS GOING TO BE TOUGH! I'M SURE I CAN PASS MY SCIENCE TEST EASILY...
LOOK WHO'S HERE! IT'S THE FOUR-EYED BOOKWORM!
THIS SQUARE'S A PUSHOVER!
WHAT?
HAW! HAW! THAT'S A GOOD ONE, JACKIE!
4

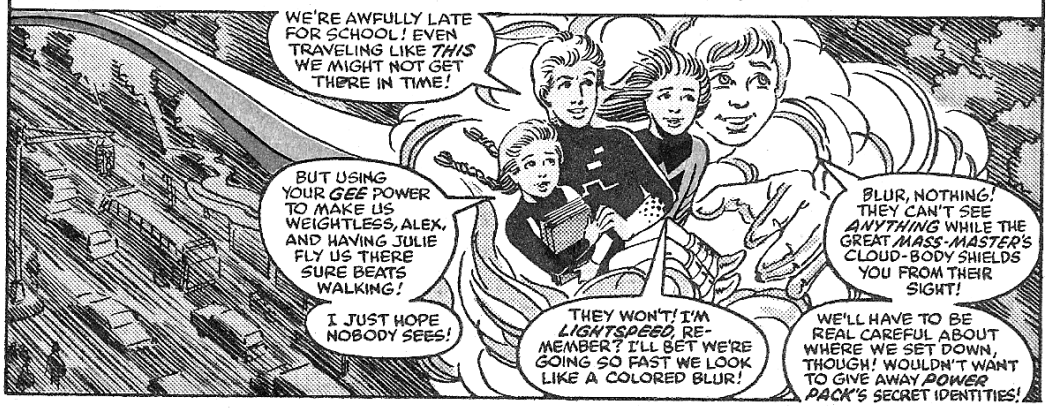

"HE GREW USED TO SUCH CRUEL PUNISHMENT! THE ONLY FRIENDS THIS BOY HAD WERE THE BOOKS HE STUDIED IN THE LIBRARY...
THE MORE I LEARN THE MORE I REALIZE HOW LITTLE I KNOW! THE THEORY OF RELATIVITY, FOR EXAMPLE...
QUIET
THEN ONE DAY...
EXCUSE ME, IS THIS SEAT TAKEN?
UH... NO!
SAY, HAVEN'T I SEEN YOU AROUND HERE BEFORE? YOU'RE THE KID WHOSE NOSE IS ALWAYS BURIED IN A TEXTBOOK!
MY NAME'S STEVEN WESTCOTT, BUT YOU CAN CALL ME SKIP!
UM, HI, SKIP!
LIBRARY
WHICH WAY DO YOU LIVE? I NEVER WALKED EINSTEIN HOME BEFORE!
YOU DON'T HAVE TO, SKIP!
I WANT TO! EINSTEIN, THIS IS THE BEGINNING OF A BEAUTIFUL FRIENDSHIP!
"AND THEY DID BECOME FRIENDS!
SEE YOU TOMORROW, EINSTEIN!
THANKS FOR HELPING ME WITH MY SCIENCE PROJECT, SKIP!
I USED TO WORRY THAT HE DIDN'T HAVE ANY FRIENDS UNTIL THAT NICE WESCOTT BOY CAME ALONG! HE SEEMS LIKE SUCH A FINE YOUNG MAN, ANNA!
5


"THE BOYS SPENT HOURS TOGETHER DISCUSSING ALL OF LIFE'S IMPORTANT PROBLEMS...
"SKIP'S PARENTS WERE DIVORCED, SO HE LIVED WITH HIS MOTHER! WHILE SHE WAS AT WORK, THE BOYS WERE ON THEIR OWN!
THIS GAME REMINDS ME OF OUR SOLAR SYSTEM! THE CUE BALL REPRESENTS THE SUN, THE OTHER BALLS ARE PLANETS, AND...
DON'T YOU EVER STOP THINKING, EINSTEIN? HEY, I'VE GOT SOMETHING TO SHOW YOU THAT'S GUARANTEED TO TAKE YOUR MIND OFF SCIENCE!
BET YOU'VE NEVER SEEN PICTURES LIKE THOSE IN A STUFFY TEXTBOOK!
UH, NO!
GIRLIE
"THE YOUNGER BOY WAS SHOCKED BY WHAT HE SAW IN THAT MAGAZINE!
COME ON, EINSTEIN! LET'S CONDUCT A LITTLE EXPERIMENT OF OUR OWN! LET'S SEE IF WE CAN TOUCH EACH OTHER LIKE THE PEOPLE IN THAT MAGAZINE!
PLEASE, SKIP, DON'T! I'VE GOT TO GO NOW!
"BUT THE YOUNG BOY WAS TOO FRIGHTENED TO LEAVE...
"DAYS LATER, HIS AUNT AND UNCLE NOTICED THAT HE WAS NO LONGER SPENDING ANY TIME WITH SKIP, AND THEY QUESTIONED HIM ABOUT IT. AFTER MUCH HESITATION, HE SOMEHOW FOUND THE COURAGE TO TELL THEM WHAT HAPPENED."
JUST LIKE YOU, HE DID THE RIGHT THING! WHEN SOMETHING YOU CAN'T HANDLE BY YOURSELF HAPPENS, YOU MUST TELL AN ADULT!
I KNOW, TONY! THAT YOUNG BOY WAS ME!
6


DO YOU THINK YOU CAN TELL YOUR PARENTS WHAT HAPPENED TO YOU?
I THINK SO! THEY LEFT THE ADDRESS OF THE PARTY THEY'RE AT BY THE PHONE--IN CASE OF EMERGENCY!
THIS QUALIFIES!
QUEENS ISLAND
AND SO...
HANG ON TIGHT, TONY!
WOW!
... AND AWAY WE GO!
MINUTES LATER ACROSS TOWN...
OPEN UP! IT'S ME, YOUR FRIENDLY NEIGHBORHOOD GATECRASHER!
WHAT IS GOING ON?! HE'S GOT OUR TONY!
AND WE'RE ON THE EIGHTEENTH FLOOR!
OH, MY!
THAT REMINDS ME OF A NEW YORKER CARTOON!
7


AFTER ALLOWING THE WEB-SLINGER AND TONY IN...
WHAT'S THE MEANING OF THIS? I DEMAND AN EXPLANATION!
TONY! ARE YOU ALL RIGHT?
I'M OKAY, MOM, DAD--THANKS TO SPIDEY!
LATER, IN THE PRIVACY OF ANOTHER ROOM...
TONY HAS SOMETHING VERY IMPORTANT TO TELL BOTH OF YOU!
GO AHEAD, SON! DON'T BE AFRAID!
IT ISN'T EASY FOR HIM, BUT ONCE AGAIN, TONY TELLS ABOUT HOW HIS BABY-SITTER TOUCHED HIM...
I'M SO PROUD OF YOU, TONY! I KNOW IT WASN'T EASY FOR YOU TO TALK ABOUT!
THANKS FOR TELLING US, TONY!
HOW CAN WE EVER THANK YOU, SPIDER-MAN?
BELIEVE IT OR NOT, YOU ALREADY HAVE!
BYE, SPIDEY, AND THANKS!
AS SPIDEY RACES BACK HOME TO HIS DARK ROOM...
I'VE NEVER ADMITTED IT TO MYSELF BEFORE, BUT FOR YEARS I'VE BEEN HAUNTED--ASHAMED OF THAT PART OF MY PAST! LIKE TONY I THOUGHT I DID SOMETHING WRONG!--THAT I WAS RESPONSIBLE!
IT WASN'T UNTIL TONIGHT, AND TONY'S SIMILAR EXPERIENCE, THAT I FINALLY TRULY REALIZED THAT WHAT HAPPENED BACK THEN WASN'T MY FAULT! IT REALLY WASN'T MY FAULT!
AND I OWE IT ALL TO TONY!
The End

Alex, Julie, Jack and Katie Power — they were four normal brothers and sisters, just like you and me. Then they were caught in the middle of an alien war and given super powers. Now they're **Gee**, **Lightspeed**, **Mass Master** and **Energizer** — and together they're known as **Power Pack**!



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MOM BELIEVES HIM! WHY NOT? I DO TELL LIES... SOMETIMES! BUT NOT THIS TIME!
GOT TO GET OUT OF HERE... GET AWAY...
...HURRY ON TO SCHOOL OR I'LL BE LATE AND MOM AND DAD WILL...
...WILL WHAT? WHAT ELSE CAN THEY DO TO ME?
LISTEN TO THEM! THEY'RE STILL ARGUING!
WHY DID I OPEN MY BIG MOUTH? WHY?!?
I SHOULD'VE RUN AWAY A LONG TIME AGO!
Dear Mom,
I hate what Dad's been doing to me. I feel like I'm bad, like it's all my fault! I tried to tell you but you wouldn't listen, so I have to leave.
Good-bye.
I love you.
Jane
2


LATER...
HI, MOM!
HI, JULIE! WHERE'S JANE? WASN'T SHE COMING OVER TO WORK ON YOUR SCIENCE PROJECT?
BRING! BRING!
SHE WASN'T IN SCHOOL. I GUESS SHE--
HELLO? HI, LOIS! NO, JANE ISN'T HERE. WE HAVEN'T SEEN HER! WHY?
JANE LEFT A NOTE? SHE'S RUN AWAY?
MOM, LISTEN! I KNOW WHERE SHE MIGHT BE! CAN WE GO LOOK FOR HER?
ALL RIGHT, HONEY! BUT BE CAREFUL!
WHERE TO, JULIE?
I DON'T REALLY KNOW WHERE! I MADE THAT PART UP, ALEX!
C'MON! WITH OUR POWERS, I'LL BET WE CAN FIND HER FAST!
KATIE, C'MON! WHAT'RE YOU DOING?
SHE'S DISINTEGRATING THAT TRASH ...ABSORBING ENERGY FROM IT!
I CAN SEE THAT, DOPE! BUT WHY?
'CAUSE I'M THE ENERGIZER, THAT'S WHY! WHAT IF JANE'S IN TROUBLE AND WE HAVE TO RESCUE HER?
I NEED TO GET ENERGIZED IF I'M GONNA USE MY POWER BALLS, DON'T I?
EXIT
GIMME A BREAK!
STEP ON IT, KATIE! LET'S SWITCH TO OUR COSTUMES AND GET GOING!


OKAY, EVERYBODY! COSTUMES ON!
AND EVEN AS THEY LAUNCH THEMSELVES INTO THE AIR, THEIR SPECIAL COSTUMES APPEAR...
HOURS LATER...
IT'S GETTING COLD AND DARK! WE'LL NEVER FIND HER! I THINK WE SHOULD JUST GIVE UP!
MAYBE JACK'S RIGHT! MOM DOESN'T KNOW ABOUT OUR POWERS AND SHE'LL WORRY...
WE CAN'T STOP, ALEX! WHITEY CAME FROM OUTER-SPACE AND GAVE US OUR POWERS TO SAVE THE WORLD!
SO WE SHOULD AT LEAST BE ABLE TO SAVE ONE FRIEND! AND IF WE'RE COLD AND TIRED, THINK OF JANE! SHE'S ALL ALONE DOWN THERE!
HEY, LOOK!
GRRROWLPH!
GRRRR
IT'S JANE!
AND THAT MEAN DOG'S GOT HER CORNERED!
WE'VE GOT TO SCARE HIM OFF! BUT HOW?
THAT DOG'S NO PROBLEM! I'LL STOP IT WITH MY POWER BALL!
SEE, JACK! I TOLD YOU GETTING ENERGIZED WOULD COME IN HANDY!
YARLP!
GREAT! WE'LL LAND AROUND THE CORNER, OUT OF JANE'S SIGHT!
AND WITH A CRACKLE OF ENERGY, THEIR STREET CLOTHES REAPPEAR...
4


JULIE! I'M SO GLAD TO SEE YOU! THERE WAS A BIG DOG AND--
WE LOOKED FOR YOU FOR HOURS, JANE! I WAS WORRIED WE'D NEVER FIND YOU!
YOUR MOTHER SAID YOU'D *RUN AWAY!*
I DID! AND I'M NOT GOING BACK! NOT *EVER!*
BUT ...WHY NOT?
IT'S A SECRET. I CAN'T TELL ANYBODY OR THINGS WILL ONLY GET WORSE.
BUT WE'RE YOUR FRIENDS. WHATEVER IT IS, YOU CAN TELL US... MAYBE WE CAN HELP.
DO YOU SWEAR YOU WON'T TELL ANYONE ELSE?
YOU HAVE OUR WORD.
WELL, IT'S MY DAD... HE'S BEEN BOTHERING ME FOR YEARS... HE MAKES ME TAKE MY CLOTHES OFF. ...AND HE TOUCHES ME IN MY PRIVATE PLACES.
HE SAID IT WAS OUR SECRET AND I FEEL REALLY WEIRD ABOUT IT.
BUT MY MOTHER SAYS THAT IF SOMEBODY TRIES TO TOUCH YOU IN WAYS YOU DON'T LIKE-- EVEN IF IT'S SOMEBODY YOU KNOW AND TRUST... LIKE A RELATIVE OR A TEACHER-- THE WAY TO STOP IT IS TO SPEAK UP AND SAY *NO!*
HOW COULD I SAY NO? HE'S MY *DAD!* AND HE SAID IT WAS OKAY BECAUSE HE LOVES ME.
SOMETIMES IT'S HARD TO SAY NO, BUT DID YOU TELL ANYBODY?
MOM SAYS THAT IF SOMEBODY TRIES TO TOUCH *US* IN WAYS WE DON'T LIKE, THAT WE SHOULD MAKE A BIG FUSS ...AND TELL A GROWN-UP, *FAST!*
IF YOU TELL, YOU WON'T GET IN TROUBLE.
I FINALLY DID! I TOLD MY MOTHER THIS MORNING... AND GUESS WHAT HAPPENED?
SHE TOLD MY FATHER AND HE SAID I WAS LYING, AND THEN THEY STARTED ARGUING AGAIN!
5


MY PARENTS ALWAYS ARGUE!
THAT'S HARD ...AND IS THERE ANYTHING ELSE THAT'S WRONG?
I FEEL LIKE I'M BAD... LIKE I DID SOMETHING TO MAKE MY DAD DO THINGS LIKE THAT!
JANE! THERE'S NOTHING WRONG WITH YOU! IT'S YOUR FATHER'S FAULT.
NO GROWN-UP SHOULD TOUCH A CHILD THAT WAY...THAT'S SEXUAL ABUSE!
MY DAD SAYS THAT IF YOU TELL ONE GROWN-UP AND HE WON'T LISTEN, YOU SHOULD TELL SOMEBODY ELSE!
WHAT ABOUT YOUR GRAND-PARENTS, OR YOUR AUNTS OR UNCLES?
THEY ALL LIVE FAR AWAY!
SO TELL A TEACHER OR A FRIEND'S MOM OR A NEIGHBOR. KEEP TELLING PEOPLE TILL SOMEBODY BELIEVES YOU!
AFTER ALL, YOU TOLD US AND WE BELIEVE YOU!
BUT YOU'RE JUST KIDS!
RUNNING AWAY ISN'T THE ANSWER, JANE!
PLEASE ...TELL A GROWN-UP!
BUT WHO?
WHAT ABOUT OUR MOM? I KNOW SHE'LL BELIEVE YOU!
AND IF SHE DOESN'T... THEN WE'LL HELP YOU FIND SOMEBODY WHO WILL!
AND SOON...
MOM, WE'RE HOME! AND LOOK! HERE'S JANE! WE FOUND HER!
6


JANE! I'M GLAD YOU'RE OKAY, HONEY! I WAS WORRIED ABOUT YOU! ARE YOU HUNGRY?
HERE! MILK AND APPLES OUGHT TO HOLD YOU TILL SUPPERTIME!
UH... MOM? JANE HAS... SORT OF A PROBLEM! SHE WANTS TO TALK TO YOU!
WHAT IS IT, HONEY?
MY DAD'S BEEN TOUCHING ME IN WAYS THAT MAKE ME UNCOMFORTABLE AND MIXED UP INSIDE--AND MY MOM WON'T BELIEVE IT! MY DAD SAYS I'M A LIAR!
I KNOW IT TOOK A LOT OF COURAGE TO TELL ME, JANE! I THINK YOU'RE VERY, VERY BRAVE!
AND I BELIEVE YOU! AND I'LL HELP YOU ALL I CAN!
DADDY! YOU'RE HOME!
MMMMM! SMELL'S GOOD! I'M STARVED! WHAT'S FOR DINNER?
JIM, COME OUT IN THE LIVING ROOM FOR A MINUTE!
7


SHE'S TELLING HIM, ISN'T SHE? HE'S GOING TO KNOW I'M BAD AND HATE ME LIKE MY DAD DOES...
...'CAUSE I SHOULDN'T HAVE TOLD THE SECRET!
BALONEY! MY DAD WON'T THINK YOU'RE BAD. TELLING WAS GOOD!
AND IT SURE TOOK A LOT OF GUTS TO DO IT! A GROWN-UP SHOULDN'T ASK A KID TO KEEP A SECRET LIKE THAT!
AND SOON...
JANE! I CALLED YOUR MOM. SHE'S UPSET AND CONFUSED, BUT SHE'S RELIEVED TO KNOW THAT YOU'RE SAFE.
LISTEN, JANE, I'M NO EXPERT IN THESE MATTERS, BUT I DO KNOW A NUMBER TO CALL WHERE FAMILIES LIKE YOURS CAN FIND HELP.
HELP? REALLY? BUT WHAT IF IT ONLY MAKES THINGS WORSE? I'M SCARED. WHAT IF I GET MY FAMILY IN TROUBLE?
ABC
DEF
THERE AREN'T ANY MIRACLES, BUT IT'S TOO IMPORTANT NOT TO TRY. THE ONLY WAY TO MAKE THINGS BETTER IS TO ASK FOR HELP.
AND, JANE, REMEMBER... WE'RE HERE AND WE BELIEVE YOU. WE'LL TRY TO HELP YOU AND YOUR FAMILY.
THE END
8

EPILOGUE

You may be wondering how these stories end, especially if something like this is happening to you. Well, for each family the ending is different, but it is always important to ask for help. Tony's parents spoke to the baby-sitter's parents, and the baby-sitter got help from someone who works with kids. She no longer bothers other children.

The Power Pack kids' parents know that adults who abuse children should be reported to the agency in that city that handles cases of sexual abuse. And that's what happened in Jane's situation. After a quiet investigation, Jane's father agreed to live with his brother for a while and to go to a place for treatment. Jane and her mother are seeing a family counselor. It isn't going to be easy for the three of them, but they are talking and starting to solve their problems.

SPECIAL INFORMATION FOR YOU AND YOUR PARENTS

1. HOW TO REPORT SEXUAL CHILD ABUSE

Sexual assault is a crime no matter how young the victim or who the offender is. There is an agency in every state that is mandated by state law to receive and to investigate reports of suspected sexual child abuse. To report suspected sexual abuse, you should notify the mandated agency in the state where the child lives. The agency is listed in the telephone directory, usually under the state's Department of Social Services, Protective Services, Social and Rehabilitative Services, or Children and Family Services. If you have difficulty finding the agency, call the police department or dial the toll-free number: (800) 422-4453.

2. TREATMENT FOR SEXUAL ABUSE

Sexual abusers and their families can be helped. Parents United is one national self-help organization with many local groups throughout the country which provides assistance to sexual abusers. Daughters and Sons United, a part of the Parents United program, provides help to child victims of sexual abuse whose parents are in the Parents United program. And, Parents Anonymous, another national self-help organization, has over 1000 chapters throughout the country for parents under stress. For information about groups near you, contact:

PARENTS UNITED / DAUGHTERS AND SONS UNITED, P.O. Box 952, San Jose, CA 95108, (408) 280-5055

PARENTS ANONYMOUS (P.A.), 22330 Hawthorne Blvd., Suite 208, Torrance, CA 90505. P.A.'s toll-free number for those outside California is (800) 421-0353; in California, call (800) 352-0386

3. HELP IF YOU'VE BEEN SEXUALLY ABUSED

The low self-esteem, anger and guilt often experienced by the victims of child sexual abuse can lead to a variety of problems in the adult survivors. Discussion or therapy groups are often helpful in resolving these problems. Most communities now offer such groups; they can be located through your local United Way Information and Referral Service or local mental health center, women's center, or rape crisis center. Parents United developed a special self-help program for older people who were sexually abused as children called AMACU. For information, contact:

ADULTS MOLESTED AS CHILDREN UNITED (AMACU), P.O. Box 952, San Jose, CA 95108, (408) 280-5055

4. NEED MORE INFORMATION?

For more information, write: Spider-Man & Power Pack, P.O. Box 2866, Chicago, IL 60690

5. WANT TO HELP?

With your help the National Committee for Prevention of Child Abuse can develop and distribute more educational materials like this comic book. Why not send your tax-free donation today to: NCPCA, P.O. Box 94283, Chicago, IL 60690. In this way, you can be part of a national movement to *stop* child abuse.


POWER PACK
AND
SPIDER-MAN
WITH
TIPS ON WAYS TO PREVENT SEXUAL ABUSE
YOUR BODY BELONGS TO YOU, AND YOU HAVE A RIGHT TO DECIDE HOW AND WHEN ANYONE TOUCHES YOU!
IF SOMEBODY TRIES TO TOUCH YOU IN WAYS THAT DON'T FEEL GOOD OR SEEM RIGHT, SAY NO!
YEAH! AND BE SURE TO TELL SOMEBODY, TOO!
AND, DON'T FORGET, IF THE FIRST PERSON YOU TELL DOESN'T BELIEVE YOU, KEEP TELLING UNTIL YOU FIND SOMEONE WHO DOES!
AND REMEMBER, IF THIS HAPPENS, IT'S NOT YOUR FAULT!
nea
national education association
The National Education Association recognizes this publication as a viable attempt to educate children about the problem of child sexual abuse.

Resources

Sexual Abuse

For Pre-Teens

- ☐ Walvoord Girard, L. (1984). *My Body is Private. Albert Whitman and Company.*
- ☐ Johnson, K. (1986). *The Trouble with Secrets. Caregivering Press.*
- ☐ Ottenweller, J. (1991). *Please Tell!: A Child's Story About Sexual Abuse. Hazelden.*
- ☐ Mayle, P. (1973). *Where Did I Come From? The facts of life without any nonsense and with illustrations. Kensington Publishing Corp.*
- ☐ Cole, J. (1988). *Asking About Sex and Growing Up: A question and answer book for boys and girls. Beach Tree Books.*

For Teens

- ☐ Wright, L. B., & Loiselle, M. B. (1997). *Back On Track: Boys Dealing with Sexual Abuse.* Safer Society Press.
- ☐ Lehman, C. (2005). *Strong at the Heart: How it Feels to Heal from Sexual Abuse.* Farrar, Straus, & Giroux.
- ☐ Carter, W. L. (2002). *It Happened to Me: A Teen's Guide to Overcoming Sexual Abuse.* San Val.
- ☐ Feuereisen, P. (2005). *Invisible Girls: The Truth About Sexual Abuse--A Book for Teen Girls, Young Women, and Everyone Who Cares about Them.* Seal Press.
- ☐ Mather, C. L. (1994). *How Long Does it Hurt? A Guide to Recovering from Incest and Sexual Abuse for Teenagers, Their Friends, and Their Families.* Jossey-Bass.

Relaxation

For Pre-Teens

- ☐ Maclean, K (2006). *Peaceful Piggy Meditation.* Albert Whitman & Co.

For Teens and Adults

- ☐ Kundtz, D. (2006). *Quiet Mind: One-Minute Retreates from a Busy World.* Conari Press.
- ☐ Lite, L. (2005, November 29). Indigo Teen Dreams: Guided Relaxation Techniques Designed to Decrease Stress, Anger, and Anxiety while Increasing Self-esteem and Self-awareness.
- ☐ Kastner, L. P., & Wyatt, J. (2009). *Getting to Calm: Cool-Headed Strategies for Caregivering Tweens and Teens.* Caregiver Map.

Cognitive Coping

For Pre-Teens

- ❑ Shapiro, L. S. & Shapiro, L. S. (2001). *They Hyena Who Lost Her Laugh.* Childswork/Childsplay.
- ❑ Holmes, M. M. (2001). *A Terrible Thing Happened.* Magination Press of the American Psychological Association.
- ❑ Levy, J. (2004). *Finding the Right Spot: When Kids Can't Live with Their Caregivers.* Magination Press of the American Psychological Association.

For Teens

- ❑ Moles, K. C. (2001). *The Teen Relationship Workbook: For Professionals Helping Teens to Develop Healthy Relaitonships and Prevent Domestic Violence.* Wellness Reproductions and Publishing, Inc.
- ❑ Hay, L. (2000). *Wisdom Cards*. Hay House.
- ❑ Hay, L. (2001). *Power Thought Cards for Teens*. Hay House.
- ❑ Vanzant, I. (2003). *Tips for Daily Living Cards*. Hay House.

Affect Regulation

For Pre-Teens

- ❑ Nass, M. S. (2001). *The Lion Who Lost His Roar: A Story About Facing Your Fears.* Childswork/Childsplay, LLC.
- ❑ Curtis, J. L. (1998). *Today I Feel Silly and Other Moods That Make My Day.* Harper Collins.
- ❑ Sobel, M. (2001). *The Penguin Who Lost Her Cool: A Story About Controlling Your Anger.* Childswork/Childsplay, LLC.
- ❑ Huebner, D. (2007). *What to Do When Your Temper Flares.* Magination Press of the American Psychological Association.
- ❑ Madison, D. L. (2002). *The Feelings Book: The care and keeping of your emotions.* Pleasant Company Publications.
- ❑ Crist, J. (2004). *What To Do When You're Scared & Worried*. Free Spirit Publishing.
- ❑ Huebner, D. (2006). *What to Do When You Grumble Too Much.* Magination Press of the American Psychological Association.

Traumatic Grief

For Pre-Teens:

- ❑ Krasney Brown, L., & Brown, M. (1998). *When Dinosaurs Die: A Guide to Understanding Death.* Little, Brown and Company.
- ❑ Schweibert, P., DeKlyen, C., & Bills, T. (2005). *Tear Soup.* Acta Publications.

- ☐ Vigna, J. (1991). *Saying Goodbye to Daddy.* Morton Grove: Albert Whitman & Co.
- ☐ Clifton, L. (1988). *Everett Anderson's Goodbye.* Reading Rainbow.
- ☐ Hickman, M. (1984). *Last Week My Brother Anthony Died.* Nashville: Abington Press.
- ☐ Claudy, A. (1984). *Dusty Was My Friend.* Human Science Press.

For Teens:

- ☐ Grollman, E. A. (1993). *Straight Talk About Death for Teenagers.* Boston: Beacon Press.
- ☐ Wolfelt, D. A. (2001). *Healing Your Grieving Heart for Teens: 100 practical ideas to help with healing in grief.* Companion Press.
- ☐ Samuel-Traisman, E. (1992). *Fire in My Heart, Ice in My Veins: A Journal for Teenagers Experiencing Loss.* Centering Corp.
- ☐ Hughes, L. B. (2005). *You Are Not Alone: Teens Talk About Life After the Loss of a Caregiver.* Boston: Scholastic Press.
- ☐ Hermes, P. (1982). *You Shouldn't Have to Say Goodbye.* New York: Harcourt Brace Jovanovich.
- ☐ Blume, J. (1987). *Tiger Eyes.* Scarsdale: Bradbury Press.
- ☐ Schotter, R. (1979). *A Matter of Time.* New York: Collins Press.

Foster Care

- ☐ Wilgocki, J., Wright, M., & Geis, A. (2002). *Maybe Days*. American Psychological Association.
- ☐ Temple-Plotz, L. (2002). *Practical Tools for Foster Caregivers*. Boys Town Press.
- ☐ Lovell, C. (2005). *The Star: A Story to Help Young Children Understand Foster Care.* Spartan Graphics.
- ☐ Blomquist, G. & Blomquist, P. (1991). *Zachary's New Home: A Story for Foster and Adopted Children.* Magination Press of the American Psychological Association.
- ☐ Fahlberg, V. (1994). *A Child's Journey Through Placement*. Perspectives Press.
- ☐ O'Malley, B. (2005). *My Foster Care Journey: A Foster/Adoption Lifebook*. Adoption-Works.

Domestic Violence

For Pre-Teens:

- ☐ Davis, D. (1984). *Something is Wrong at My House: A Book About Caregivers Fighting*. Parneting Press, Inc.

- ❑ Holmes, M. M. (2001). *A Terrible Thing Happened.* Magination Press of the American Psychological Association.

For Teens:

- ❑ Motes, K. (2001). *The Teen Relationship Workbook.* Wellness Reproductions and Publishing.

Parenting

- ❑ Whitham, C. M. (1991). *Win the Whining War and Other Skirmishes: A Family Peace Plan (for school age children).* Perspective Publishing.
- ❑ Chansky, T. E. (2004). *Freeing Your Child from Anxiety: Powerful, Practical Solutions to Overcome Your Child's Fears, Worries, and Phobias.* Broadway.
- ❑ Phelan, T. W. (2004). *1-2-3 Magic: Effective Discipline for Children 2-12, 3rd Edition.* Caregivermagic, Inc.
- ❑ Kastner, L. P., & Wyatt, J. (2009). *Getting to Calm: Cool-Headed Strategies for Caregivering Tweens and Teens.* Caregiver Map.
- ❑ Stevenson, H. C., Davis, G., & Abdul-Kabir, S. (2001). *Stickin' To, Watchin' Over, and Gettin' With: An African American Caregiver's Guide to Discipline.* Jossey-Bass: A Wiley Company.
- ❑ Rodriquez, G. (1999). *Raising Nuestros Ninos: Bringing up Latino Children in a Bicultural World.* Fireside.

Professionals

- ❑ Oppenheim, D. & Goldsmith, D. (2007). *Attachment Theory in Clinical Work with Children: Bridging the Gap between Research and Practice.* The Guildford Press.
- ❑ Taffel, R. (2004). *Getting Through to Difficult Kids and Caregivers: Uncommon Sense for Child Professionals.* The Guilford Press.
- ❑ Lowenstein, L. (2008). *Assessment and Treatment Activities for Children, Adolescents, and Families: Practitioners Share Their Most Effective Techniques.* Champion Press.
- ❑ Lowenstein, L. (1999). *Creative Interventions for Troubled Children and Youth.* Champion Press.

References:

Adams, C. A. (1992). *Helping Your Child Recover From Sexual Abuse.* University of Washington Press.

Arneson, L.-M. (n.d.). Memory Garden Card Game. Bright Spots Games.

Arneson, L.-M. (n.d.). Thoughts and Feelings Card Game. Bright Spots Games.

Aronson Fontes, L. (2008). *Child Abuse and Culture: Working with Diverse Families.*

Barden, L. M. (n.d.). The Peace Path Game. WPS Creative Therapy Stores.

Bean, B., & Bennett, S. (1993). *A Guide for Teen Survivors: The Me Nobody Knows.* Jossey-Bass Publishers.

Bell, R. (1998). Changing Bodies, Changing Lives, 3rd Edition. Three Rivers Press.

Blomquist, G. & Blomquist, P. (1991). *Zachary's New Home: A Story for Foster and Adopted Children.* Magination Press of the American Psychological Association.

Blume, J. (1987). *Tiger Eyes.* Scarsdale: Bradbury Press.

Brohl, K. (2004). *When Your Child Has Been Molested.* Jossey-Bass.

Brown, L. K., & Brown, M. (1996). *When Dinosaurs Die: A Guide to Understanding Death.* Laura Krasney Brown and Marc Brown.

Cain, J. (2000). *The Way I Feel.* Parenting Press, Inc.

Carter, W. L. (2002). *It Happened to Me: A Teen's Guide to Overcoming Sexual Abuse.* San Val.

Cavanaugh-Johnson, T. (1992). Let's Talk About Touching: A Therapeutic Game.

Cavanaugh-Johnson, T. (1995). *Child Sexuality Curriculum for Abused Children and their Parents.* Jossey-Bass.

Cavanaugh-Johnson, T. (1995). *Treatment Exercises for Child Abuse Victims and Children with Sexual Behavior Problems.* Jossey-Bass.

Cavanaugh-Johnson, T. (2003). *Understanding Children's Sexual Behaviors: What's Natural and Healthy.* Jossey-Bass.

Chansky, T. E. (2004). *Freeing Your Child from Anxiety: Powerful, Practical Solutions to Overcome Your Child's Fears, Worries, and Phobias.* Broadway.

Childress, R., & Gillis, J. (1977). A study of pretherapy role induction as an influence process. *Journal of Clinical Psycholoy* , 540-544.

Clark, J. I. (1999). *Time-In: When Time-Out Doesn't Work.* Parenting Press, Inc.

Clark, L. P. (2001). *SOS Help for Emotions: Managing Anxiety, Anger & Depression.* Parents Press.

Claudy, A. (1984). *Dusty Was My Friend.* Human Science Press.

Clifton, L. (1988). *Everett Anderson's Goodbye.* Reading Rainbow.

Cohen, B., Barnes, M., & Rankin, A. (1995). *Managing Traumatic Stress Through Art: Drawing from the Center.* Sidran Press.

Cohen, J. A., Mannarinbo, A. P., & Deblinger, E. P. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents.* Guilford Press.

Cole, J. (1988). *Asking About Sex and Growing Up: A question and answer book for boys and girls.* Beach Tree Books.

Conlin, S., & Levine Friedman, S. (1989). *Let's Talk About Feelings: Ellie's Day.* Parenting Press, Inc.

Crary, E. (1999). *Amor y Limites: Una Guia Para Ser Padres Creativos.* Parenting Press, Inc.

Crary, E., & Katayama, M. (2008). *Self-Calming Cards/Tarjetas para calmarse.* Parenting Press, Inc.

Crist, J. (2004). *What To Do When You're Scared & Worried*. Free Spirit Publishing.

Cunningham, C., & McFarlane, K. *When Children Abuse: Group Treatment Strategies for Children with Impulse Control Problems.* Safer Society Press.

Curtis, J. L. (1998). *Today I Feel Silly and Other Moods That Make My Day.* Harper Collins.
Davis, D. (1984). *Something is Wrong at My House: A Book About Parents Fighting*. Parenting Press, Inc.
Deaton, W., & Johnson, K. (2002). *Living with My Family: A workbook.* Hunter House.
DeBecker, G. (1999). *Protecting the Gift: Keeping Children and Teenagers Safe.* Dell.
Deblinger, E., & Heflin, A. H. (1996). *Treating Sexually Abused Children and Their Nonoffending Parents: A Cognitive Behavioral Approach.* Sage Publications.
Deblinger, E., Neubauer, F., Runyon, M., & Baker, D. (n.d.). What Do You Know? CARES Institute.
Cain, B. & Patterson, A. (2001). *Double-Dip Feelings: Stories to Help Children Understand Emotions*. Magination Press of the American Psychological Association.
Drost, J., & Bayley, S. (2001). *Therapeutic Groupwork with Children.* Speechmark Publishing Ltd.
Fahlberg, V. (1994). *A Child's Journey Through Placement*. Perspectives Press.
Family Institute of Northern Utah. (n.d.). You Decide: An innovative educational game teaching non-violent skills for children ages 6-12.
Feuereisen, P. (2005). *Invisible Girls: The Truth About Sexual Abuse--A Book for Teen Girls, Young Women, and Everyone Who Cares about Them.* Seal Press.
Freeman, L. (1982). *It's My Body: A book to teach young children how to resist uncomfortable touch.* Parenting Press, Inc.
Gardner, R. A. (2004). *Psychotherapeutic Use of the Talking, Feeling & Doing Game*. Bureau for at Risk Youth.
Greene, C. (1976). *Beat the turtle drum.* New York: Viking Press.
Grollman, E. A. (1993). *Straight Talk About Death for Teenagers.* Boston: Beacon Press.
Grollman, E. A. (1990). *Talking About Death.* Boston: Beacon Press.
Hader, E. P. *Play it Safe with SASA.*
Harrison, M. A. *A Safe Place to Live.* Kidsrights.
Hay, L. (2000). *Wisdom Cards*. Hay House.
Hay, L. (2001). *Power Thought Cards for Teens*. Hay House.
Henkes, K. (1997). *Sun & Spoon.* New York: Greenwillow Books.
Hermes, P. (1982). *You Shouldn't Have to Say Goodbye.* New York: Harcourt Brace Jovanovich.
Herrerías, C. M. *La guia de los niños a quien tu puedes confiar: Protege en la casa, en la escuela y el Internet.* Kidsrights.
Hesse, K. (1993). *Puppy's Chair.* New York: Macmillan Publishing Company.
Hewitt, S. (. *Please Tell! A Child's Story About sexual abuse.* Hazelden Foundation.
Hickman, M. (1984). *Last Week My Brother Anthony Died.* Nashville: Abington Press.
Hindman, J. *A Very Touching Book... for little people and for big people.*
Holmes, M. M. (2001). *A Terrible Thing Happened.* Magination Press of the American Psychological Association.
Huebner, D. (2003). *Sometimes I Worry Too Much, But Now I Know How to Stop.* Magination Press of the American Psychological Association.
Huebner, D. (2008). *What to Do When Bad Habits Take Hold.* Magination Press of the American Psychological Association.
Huebner, D. (2008). *What to Do When You Dread Your Bed.* Magination Press of the American Psychological Association.
Huebner, D. (2006). *What to Do When You Grumble Too Much.* Magination Press of the American Psychological Association.

Huebner, D. (2005). *What to Do When You Worry Too Much.* Magination Press of the American Psychological Association.
Huebner, D. (2007). *What to Do When Your Brain Gets Stuck.* Magination Press of the American Psychological Association.
Huebner, D. (2007). *What to Do When Your Temper Flares.* Magination Press of the American Psychological Association.
Hughes, L. B. (2005). *You Are Not Alone: Teens Talk About Life After the Loss of a Parent.* Boston: Scholastic Press.
Hunter House, Inc. *Growth and Recovery Workbooks.*
I Want Your Moo. Magination Press of the American Psychological Association.
Johnson, K. (1986). *The Trouble with Secrets.* Parenting Press.
Josh's Smiley Faces. (n.d.). Magination Press of the American Psychological Association.
Joslin, K. R. *Positive Parenting From A to Z.* Fawcett Columbine/Ballantine Books.
Karp, C. L., & Butler, T. L. *Activity Book for Treatment Strategies for Abused Children.* Sage Publications.
Kastner, L. P., & Wyatt, J. (2009). *Getting to Calm: Cool-Headed Strategies for Parenting Tweens and Teens.* Parent Map.
Kehoe, P. P. *Helping Abused Children.*
Kiblar, M. (n.d.). Feelings Cards. Kidsrights.
Kolko, D., & Swenson, C. C. *Assessing and Treating Physically Abused Children and Their Families: A Cognitive-Behavioral Approach.* Sage Publications.
Koplow, L. *Tanya y el Hombre Tobo.* Magination Press of the American Psychological Association.
Krasney Brown, L., & Brown, M. (1998). *When Dinosaurs Die: A Guide to Understanding Death.* Little, Brown and Company.
Kundtz, D. (2006). *Quite Mind: One-Minute Retreates from a Busy World.* Conari Press.
Lamblin, C. *Luisa dice palabrotas.* Luis Vives Editorial.
Lamb-Shapiro, J. & Lamb-Shapiro (2001). *The Hyena Who Lost Her Laugh.* Childswork/Childsplay, LLC.
Lamb-Shapiro. *The Bear Who Lost His Sleep: A Story About Worrying Too Much.* Childswork/Childsplay, LLC.
Leben, N., & Acquaro, F. (n.d.). Feelings Wheel Game. Morning Glory Treatment Center for Children.
Letson, T. M. *4 Downs to Anger Control.* Finish Line Press.
Levy, J. (2004). *Finding the Right Spot: When Kids Can't Live with Their Parents.* Magination Press of the American Psychological Association.
Lehman, C. (2005). *Strong at the Heart: How it Feels to Heal from Sexual Abuse*. Farrar, Straus, & Giroux.
Lite, L. (2005, November 29). Indigo Teen Dreams: Guided Relaxation Techniques Designed to Decrease Stress, Anger, and Anxiety while Increasing Self-esteem and Self-awareness.
Loftis, C. *The Boy Who Sat By The Window.* New Horizon Press.
Loftus, E. F. (1993). The Reality of Repressed Memories. *American Psychologist* , 518-537.
Loiselle, M. B., & Bailey Wright, L. *Shining Through: Pulling it Together After Sexual Abuse, 2nd Edition.*
Lorenzen, K. (1983). *Lanky Longless.* New York: Atheneum. A Margaret K. McElderry Book.
Lovell, C. (2005). *The Star: A Story to Help Young Children Understand Foster Care.* Spartan Graphics.
Lowden-Golightly, S. (1993). *Emily's Sadhappy Season.* Omaha: Centering Corporation.
Lowenstein, L. (2008). *Assessment and Treatment Activities for Children, Adolescents, and Families: Practitioners Share Their Most Effective Techniques.* Champion Press.
Lowenstein, L. (1999). *Creative Interventions for Troubled Children and Youth.* Champion Press.
Maclean, K (2006). *Peaceful Piggy Meditation.* Albert Whitman & Co.

Madaras, L., & Madaras, A. *My Body, My Self for Boys, workbook.* Newmarket Press.
Madaras, L., & Madaras, A. *My Body, My Self for Girls, workbook.* Newmarket Press.
Madaras, L., & Madaras, A. *The What's Happening to My Body Book for Boys.* Newmarket Press.
Madaras, L., & Madaras, A. *The What's Happening to My Body Book for Girls.* Newmarket Press.
Madison, D. L. (2002). *The Feelings Book: The care and keeping of your emotions.* Pleasant Company Publications.
Mariah, K. (n.d.). Angry Animals. Kidsrights.
Marulanda, S. *Everybody Has Feelings/Todos Tenemos Sentimientos: The Moods of Children.* Gryphon House, Inc.
Mather, C. L. (1994). *How Long Does it Hurt? A Guide to Recovering from Incest and Sexual Abuse for Teenagers, Their Friends, and Their Families.* Jossey-Bass.
Mayle, P. *What's Happening to Me? An Illustrated Guide to Puberty.* Kensington Publishing Corp.
Mayle, P. (1973). *Where Did I Come From? The facts of life without any nonsense and with illustrations.* Kensington Publishing Corp.
Merrell, K. W. (2008). *Behavioral, Social, and Emotional Assessment of Children and Adolescents, Second Edition.* Mahwah: Taylor and Francis.
Mitlin, M. L. (n.d.). Emotional Bingo.
Moles, K. C. (2001). *The Teen Relationship Workbook: For Professionals Helping Teens to Develop Healthy Relaitonships and Prevent Domestic Violence.* Wellness Reproductions and Publishing, Inc.
Monahon, C. (1993). *Children and Trauma: A Guide for Parents & Professionals.* Jossey-Bass.
Moser, A. E. *Don't Be a Menace on Sundays: The Children's Anti-Violence Book.* Landmark Editions, Inc.
Moser, A. E. *Don't Feed the Monsters on Tuesdays: The Children's Self-Esteem Book.* Landmark Editions, Inc.
Moser, A. E. *Don't Pop Your Cork on Mondays: The Children's Anti-Stress Book.* Landmark Editions, Inc.
Moser, A. E. *Don't Rant and Rave on Wednesdays: The Children's Anger-Control Book.* Landmark Editions, Inc.
Moser, A. E. *Don't Tell a Whopper on Fridays: The Children's Truth-Control Book.* Landmark Editions, Inc.
Motes, K. (2001). *The Teen Relationship Workbook.* Wellness Reproductions and Publishing.
Mundy, M. *Mad Isn't Bad.* One Caring Place/Abbey Press.
Mundy, M. *Sad Isn't Bad.* One Caring Place/Abbey Press.
Munson, L., & Riskin, K. *In Their Own Words: A Sexual Abuse Workbook for Teenage Girls.*
Nass, M. S. (2001). *The Lion Who Lost His Roar: A Story About Facing Your Fears.* Childswork/Childsplay, LLC.
Nass, M. S. *The Rabbit Who Lost His Hop: A Story About Self-Control.* Childswork/Childsplay, LLC.
Norac, C. *Las Palabras Dulces.* Editorial Corimbo.
O'Malley, B. (2005). *My Foster Care Journey: A Foster/Adoption Lifebook.* Adoption-Works.
Oppenheim, D. & Goldsmith, D. (2007). *Attachment Theory in Clinical Work with Children: Bridging the Gap between Research and Practice.* The Guildford Press.
Oram, H. *Fernando Furioso.* Ediciones Ekare.
Ottenweller, J. (1991). *Please Tell!: A Child's Story About Sexual Abuse.* Hazelden.
Pacifici, C. P., Chamberlain, P. P., & White, L. (2002). *Off Road Parenting: Practical Solutions for Difficult Behavior.* Northwest Media.
Palmer, P. *The Mouse, the Monster, and Me: Assertiveness for Young People.* Impact Publishers.
Parker, M. B. (2002). *Jasper's Day.* Toronto: Kids Can Press.
Parr, T. *It's Okay to Be Different.* Megan Tingley Books/Little, Brown and Company.

Parr, T. *The Family Book.* Megan Tingley Books/Litte, Brown and Company.
Parr, T. *The Feel Good Book.* Megan Tingley Books/Little, Brown and Company.
Patterson, G., & Forgotch, M. *Parents and Adolescents Part I: The Basics.* Research Press.
Phelan, T. W. (2004). *1-2-3 Magic: Effective Discipline for Children 2-12, 3rd Edition.* Parentmagic, Inc.
Plugokinski, E. P. (n.d.). Dealing with Feelings Card Game.
Porett, J. *When I Was Little Like You.* Child Welfare League of America.
Rodriquez, G. (1999). *Raising Nuestros Ninos: Bringing up Latino Children in a Bicultural World.* Fireside.
Rohlfs Burke, C. (n.d.). Survivor's Journey: A therapeutic game for working with survivor's of sexual abuse. Kidsrights.
Samuel-Traisman, E. (1992). *Fire in My Heart, Ice in My Veins: A Journal for Teenagers Experiencing Loss.* Centering Corp.
Sanford, D. *I Can't Talk About It: A child's book about sexual abuse.* Gold'n Honey Books.
Sayre, J. *Somos un Arcoiris / We Are a Rainbow.* Charlesbridge.
Schader, K. (n.d.). Dr. Playwell's Worry-Less Game. Childswork/Childsplay, LLC.
Schor, H. *A Place for Starr.* Kidsrights.
Schotter, R. (1979). *A Matter of Time.* New York: Collins Press.
Schweibert, P., DeKlyen, C., & Bills, T. (2005). *Tear Soup.* Acta Publications.
Shapiro, L. E. *All Feelings are OK - It's what you do with them that counts.*
Shapiro, L. E. (n.d.). The Empathy Game. Childswork/Childsplay, LLC.
Shapiro, L. E. *The Koala Who Wouldn't Cooperate: A Story About Responsible Behavior.* Childswork/ Childsplay, LLC.
Shapiro, L. E. (n.d.). The You and Me Card Game. Childswork/Childsplay, LLC.
Shapiro, L. S. & Shapiro, L. S. (2001). *They Hyena Who Lost Her Laugh.* Childswork/Childsplay.
Sheppard, C. *A Story for Traumatized and Grieving Children.* The Institute for Trauma and Loss in Children.
Shook-Hazen, B. (1985). *Why Did Grandpa Die?* Racine: Western Publishing.
Sobel, M. (2001). *The Penguin Who Lost Her Cool: A Story About Controlling Your Anger.* Childswork/ Childsplay, LLC.
Something Happened and I'm Scared to Tell.
Spelman, C. *Your Body Belongs To You.* Albert Whitman and Co.
Stanek, M. *Don't Hurt Me Mamma.* Albert Whitman and Co.
Stauffer, L. P., & Deblinger, E. P. *Let's Talk About Coping and Safety Skills: A Workbook about Taking Care of ME!* Hatfield: Hope for Families, Inc.
Stauffer, L. P., & Deblinger, E. P. *Let's Talk About Taking Care of You! An Educational Book about Body Safety.* Hatfield: Hope for Families, Inc.
Stevenson, H. C., Davis, G., & Abdul-Kabir, S. (2001). *Stickin' To, Watchin' Over, and Gettin' With: An African American Parent's Guide to Discipline.* Jossey-Bass: A Wiley Company.
Taffel, R. (2004). *Getting Through to Difficult Kids and Parents: Uncommon Sense for Child Professionals.* The Guilford Press.
Temple-Plotz, L. (2002). *Practical Tools for Foster Parents*. Boys Town Press.
The Goodbye Game. (n.d.). Childswork/Childsplay, LLC.
The New Jersey Task Force on Child Abuse and Neglect. *Gilbert the Gilfish Races for the Rainbow (coloring book).* NJ Division of Youth and Family Services (DSCYF).
Tiffault, B. (1992). *A Quilt for Elizabeth.* Omaha: Centering Corporation.
Uncle Willy's Tickles. Magination Press of the American Psychological Association.

Vanzant, I. (2003). *Tips for Daily Living Cards*. Hay House.
Verdick, E. *Words Are Not for Hurting.* Free Spirit Publishing.
Verdick, E., & Lisovskis, M. *How to Take the Grrrr Out of Anger.* Free Spirit Publishing.
Vigna, J. (1991). *Saying Goodbye to Daddy.* Morton Grove: Albert Whitman & Co.
Walvoord Girard, L. (1984). *My Body is Private.* Albert Whitman and Company.
Watcher, O. *No More Secrets for Me.*
Whitehouse, E. a. *A Volcano in My Tummy.* New Society Publishers.
Whitham, C. M. (1991). *Win the Whining War and Other Skirmishes: A Family Peace Plan (for school age children).* Perspective Publishing.
Whitman, C. M. (1994). *"The Answer is No" Saying It and Sticking To It (Ages 2 - 12).* Perspective Publishing.
Whitman, C. M. *Gana la Guerra de los Berrinches y Otras Contiendas: Un plan de paz familiar.* Perspective Publishing.
Whitman, C. M. *La Respuesta es No.* Amat Editorial.
Wilgocki, J., Wright, M., & Geis, A. (2002). *Maybe Days*. American Psychological Association.
Williams, M. B., & Poijula, S. P. *The PTSD Workbook.*
Wolfelt, D. A. (2001). *Healing Your Grieving Heart for Teens: 100 practical ideas to help with healing in grief.* Companion Press.
Wright, L. B., & Loiselle, M. B. (1997). *Back On Track: Boys Dealing with Sexual Abuse.* Safer Society Press.
Wright, W., & Kahn. *Maybe Days: A Book for Children in Foster Care.* Magination Press of the American Psychological Association).

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