CHAPTER

One

How Structured, Sensory Interventions Help Grieving and Traumatized Children

This first chapter begins with a brief history of what we learned at the National Institute for Trauma and Loss in Children (TLC) while working with grieving and traumatized children who had been exposed to a variety of violent and nonviolent experiences. Established in 1990, TLC is a program of the Starr Global Learning Network of Starr Commonwealth, which has been helping children and adolescents flourish for the past 100 years. The children taught us what mattered most in their efforts to overcome their painful and overwhelming experiences, which lead to the development of the evidence-based *Structured Sensory Interventions for Children, Adolescents and Parents* (*SITCAP*) programs presented in detail in this text. The *SITCAP* model meets the criteria validating it as a practice-based and an evidence-based intervention model. This criteria and how it is supported by *SITCAP* is reviewed, as funding sources are more frequently requesting that today's interventions meet these requirements.

In addition, a distinction is made between nonviolent and violent situations to illustrate that the subjective experiences of children, not the nature of the situation, determine whether the experiences are grief or trauma inducing. This is followed by a very simple yet profound mandate by children and a brief discussion regarding its implications for treatment. This introduction becomes essential to understanding the *Core Principle* and *Key Concepts* of *SITCAP* presented in subsequent chapters. These concepts describe how children's subjective experiences are revealed and utilized to help diminish the painful, overwhelming, and terrifying reactions they can experience. Similar to Lenore Terr's (2008) descriptions of magical moments in psychotherapy, we also introduce *Magical Moments*, those turning points in children's lives that practitioners using *SITCAP* shared with us over the years. *Magical Moments* are featured in each chapter, in addition to *Points of Interest*, which briefly discuss a variety of subjects pertinent to helping grieving and traumatized children and adolescents. The chapter concludes with a review of two cases and their evidence-based outcomes, supporting the overall benefits experienced by those who have participated in *SITCAP* over the years.

Was It Grief or Trauma: What Matters Most?

Examining our experiences in the 1970s and 1980s with children, teens, and families who sought help while in crisis—or created a crisis to draw attention to their need for help—revealed what mattered most in our efforts to help. Grief was a common response to their crisis experiences resulting from the losses precipitating their crises—loss involving a loved one to sudden or accidental death, suicide, homicide, domestic violence, sexual and physical abuse, or terminal illness, or loss due to divorce, betrayal of trust in relationships, abandonment, homelessness, or exposure to catastrophic events. In the early 1980s, suicide became an epidemic claiming the lives of youth. At the core of the suicide experience is the loss of value for oneself, the loss of connectedness to any significant person, and the loss created for the family members and friends who are left behind. In the later 1980s, suicide rates remained high; however, violence claimed this unfortunate title of epidemic, reflecting the disturbing ways our children were now experiencing their worlds.

With these losses, we were observing reactions not only associated with grief but also with the posttraumatic stress disorder (PTSD) described in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III-R*) (APA, 1980). Unfortunately, these criteria, as defined by the *DSM-III-R*, were specific to adults. The challenge we faced was helping others acknowledge that children could, in fact, experience the reactions attributed to adults at the time. This would not occur until the mid-1990s. Practitioners in the 1980s, for example, observed adult PTSD criteria in adolescent survivors of suicide as well as those who discovered the bodies of those who took their own lives. However, it wasn't until 1993 and subsequent years that the literature began to acknowledge that discovering the body of a loved one, friend, or peer who had taken their life was traumatic (Brent et al., 1993). The term *trauma* was not formally assigned to children by the American Psychological Association until 1994, when they were included in the adult-designed PTSD diagnostic category in the *DSM-IV* (APA, 1994). This inclusion was certainly encouraged by the research that emerged in the 1980s regarding the association of PTSD with suicide and violence among children and adolescents (Pynoos & Eth, 1986; Pynoos et al., 1987).

Despite the various situations that brought children and families to our attention, so many victims showed us that grief and trauma were not necessarily separate entities; they often coexisted. Symptoms could be attributed to both grief and trauma, as we understood them at that time, but also to other disorders, making it difficult to assign treatment based on symptoms alone. What we discovered really mattered the most to those who were grieving and traumatized was *not their symptoms, but how they experienced themselves, others, and life following exposure to traumatic events in their lives.* TLC was founded in 1990 to develop an intervention process that would be helpful to both grieving and traumatized children and that could be initiated in clinical and community settings and also in schools, where children are the most accessible.

It Is Not the Situation

An Internet search for *trauma-informed care* yields more than 7 million references. It is safe to say that a great deal of information exists about the prevalence of trauma experienced by children and what constitutes trauma-informed care. The majority of articles regarding trauma consistently cite violence as the primary cause of trauma. There is no doubt that violence does induce severe trauma in children. Most would agree that at least 50% of the children in child welfare and 60% to 70% of youth in the juvenile justice system experience trauma (Hodas, 2006; Kerig & Becker, 2010). However, research began to emerge as early as the 1990s indicating that trauma can also be induced by disasters such as fires (McFarlane, Policansky, & Irwin, 1987), hurricanes (Lonigan, Shannon, Finch, Daugherty, & Taylor, 1991), boating accidents (Yule, 1992), burns, and medical procedures such as bone marrow transplants (Stubner, Nader, Yasuda, Pynoos, & Cohen, 1991). Three million people yearly are involved in car accidents; up to 45% of those injured suffer PTSD (Goodin & Abernathy, 2011). In fact, divorce can also induce trauma when the conditions of that experience leave children vulnerable (Divorce and PTSD, 2012).

We have two reasons for making this distinction between violent and nonviolent situations, which are not the result of direct intent to do harm. First, in comparison to the volumes written about the relationship between violence and trauma, we rarely read about the daily nonviolent trauma-inducing situations in children, such as homelessness. Often, trauma is not screened for in children who are exposed to situations such as a depressed parent, house fires, car fatalities, critical injuries, terminal illnesses, divorce, or victims of bullying and cyber bullying. Second, we must conclude that if both violent and nonviolent situations can induce trauma, then perhaps it is not the situation that induces trauma but how that situation is being experienced that leaves children and youth vulnerable to trauma. If this is true, then it follows that we must first know how children are experiencing what they are exposed to if we want to determine what might be the most helpful and appropriate trauma-informed response.

Children's Mandate

> If you don't think what I think, feel what I feel, experience what I experience, and see what I see when I look at myself, others, and the world around me, how can you possibly know what is best for me?

This is a simple yet profoundly wise mandate. When we can appreciate how traumatized children are experiencing themselves, others, and their lives as a result of their experiences, we can assign timely, useful, and appropriate interventions. Resilience research, for example, clearly documents that not everyone exposed to what we might consider to be a trauma-inducing incident is necessarily traumatized by that incident

(Bonanno et al., 2002). Assigning an appropriate intervention dictates that we first determine how children are experiencing what they are exposed to if we are to provide an intervention that is not itself traumatizing. In fact, the primary dictate of trauma-informed care is to avoid re-traumatizing, "to do no harm" (Hodas, 2006), by not making assumptions that children must be traumatized by what they have been exposed to or, if traumatized, that all children need the same intervention (Steele & Raider, 2001).

In essence, a situation such as divorce may not be violent or traumatizing for many children. However, even in a nonviolent divorce—one void of physical abuse and threats of bodily harm—if the child's experience of that divorce involves terror, worry, guilt, feeling powerless, and other subjective experiences associated with trauma, then that divorce may become traumatic. This is why interventions must match how children are experiencing their life events.

Implications for Treatment

The child-driven mandate presented earlier dictates that to be helpful we need to relate to grieving and traumatized children at a sensory level rather than primarily at a cognitive level. What does this mean? Today neuroscience has confirmed that trauma is experienced in the midbrain, the limbic region, sometimes referred to as the "feeling" brain or the "survival" brain, where there is no reason, logic, or language. Reason, logic, and the use of language, to make sense of what has happened, are upper brain cognitive functions that become difficult to access in trauma (Brendtro, Mitchell, & McCall, 2009; Levine & Kline, 2008; Perry, 2009; Schore, 2001; van der Kolk, McFarlane, & Weisaeth, 1996). Neuroscience also shows that "learning anything requires building new neural networks [by] being actively involved in what is being learned" (Fischer, 2012).

For these reasons, we must direct our efforts at helping children with how they are experiencing their worlds, with what they now see when they look at themselves and others as a result of their exposure to trauma. We must engage them in nonverbal, sensory-based experiences that allow them to rework their traumatic memories and their trauma-related sensations, images, and feelings in ways that also allow them to see themselves and their experience as survivors and thrivers, not victims. We must help them to see and experience others as helpful and supportive rather than threatening and unsafe, and to see and experience life as promising rather than continually painful. This goal is difficult to accomplish using cognitive-based interventions alone. If, for example, I experienced something terrifying months earlier and I am now physically safe, but elements in my environment are reminding me of that terrifying experience (my midbrain is being activated by the associated memories), then all of the verbal reassurance in the world will not calm me. I must do something that brings about a sense of safety and calms (deactivates) my midbrain responses to those past memories. Numerous examples and sensory-based activities that restore this sense of safety are presented throughout the book.

A Magical Moment

My magical moment in using *SITCAP* is about a 7-year-old boy. He had lovely eyes with an eagerness and innocence that shone through. Much of his little life had been filled with turbulence and trauma. He had witnessed violence in his home and had experienced neglect and emotional abuse. In our work together, we had been using many interventions from *SITCAP* programs. In one session, Shawn (not his real name) was telling me how he would hear his mom and dad fight a lot. I asked if he could show me how that felt in his body when he thought about it now. He drew a picture of a person with a breaking heart and said he felt sad, scared, and worried. We talked about the meaning of each feeling for him and how he experienced it in his body. Then, spontaneously, he drew an image of a worry thermometer. He exclaimed that this thermometer goes from 0 to 100, and that his worries were so big that it was more than 100 degrees, and that the thermometer broke. "That's how much I worry!" he said.

Shawn then asked me to make a string of paper dolls. He took the paper dolls, and he drew happy faces on all seven of them and asked me to draw hearts on their bodies. He called these dolls the "worry breakers." He paid special attention to the doll on the far right, calling it "a soldier." He said that this soldier is the leader, and the rest of the dolls follow to help fight and break worries. As he spoke about the power of these dolls, his eyes widened and his back straightened. I could feel his own power growing as he spoke with confidence about how he might use these dolls in his life when he starts to feel worried. We then noticed the paper that was left over from cutting out the paper dolls looked like a crown. Shawn invited me to assist with drawing hearts and stars on the crown. We then stapled the ends together and, putting it on his head, he reported, "This crown helps with sad feelings!"

We talked about how he and his mom could use his powerful new resources. We walked around the room practicing how it felt to wear the crown and how that felt different in his body and could help with sad and scared feelings. Toward the end of our session, I looked at his picture of the thermometer again and asked if he could show me how he felt now. Shawn took another piece of paper and began drawing purposefully. As he put down his marker, he looked right at me, smiling with his bright green eyes and said, "This is an angel with wings. The angel is very special because it shoots love arrows to all people who need it." There was a calm presence about him.

As a therapist, *SITCAP* helps us create a safe holding space, guided by clear clinical interventions. Knowing our own therapeutic map allows us to step aside and let the magic begin to take shape. This little fellow knew what he needed to do. He was following his own magic inside—the kind of magic that allows a beautiful unfolding of a child's healing path as he journeys toward wholeness of spirit, body, and mind.

Carmen Richardson, MSW, RSW, RCAT, REAT
Prairie Institute of Expressive Arts Therapy, Calgary, Alberta, CANADA T3C 0P9

Subjective Experiences Matter

It is well argued and supported by abundant research that traumatized children today are going undiagnosed and misdiagnosed. Trauma symptoms are often mistaken for depression, attention deficit problems, oppositional defiant disorder (ODD), conduct disorder, reactive attachment, and other disorders (van der Kolk et al., 2009). This is partly because of our traditional focus on using symptoms and deficits as criteria for diagnosis, as well as the current, very narrow PTSD diagnosis found in the *DSM-IV-TR* (APA, 2000).

In 2005 and again in 2010, Robert Pynoos, Bessel van der Kolk, and their colleagues proposed a more relevant trauma category that reflects how traumatized children are presenting today and the abundant documentation neuroscience has provided regarding trauma's impact on the brain, the body, behavior, learning, and emotions. Although not included in the *DSM-5*, the proposed Developmental Trauma Disorder (DTD) presents a much more comprehensive, representative, and descriptive view of how traumatized children experience themselves, others, and the world around them as a result of their exposure to traumatic experiences (van der Kolk et al., 2009). It also puts those experiences within a developmental perspective, which is infrequently discussed in the literature. How a divorce is experienced at age 6, for example, is completely different than how it is experienced at age 16. Interventions must be different because of the developmental differences and experiences existing between these two age groups. This is also the case, for example, when a child is chronologically age 10 but developmentally more representative of a 6-year-old. At the time of this writing, the changes being made to the PTSD category in the *DSM-5* include (1) a preschool subtype for children ages 6 and under—Posttraumatic Stress Disorder in Preschool Children, (2) a dissociative subtype, and (3) a six-month requirement for children for the bereavement-related subtype (APA, 2012).

Although the proposed DTD category remains under consideration, its focus on the subjective experiences of trauma is critical to appreciating what matters most in our efforts to best understand and respond to traumatized children. In listing the prescribed criteria for exposure, the proposed DTD lists the following subjective experiences of traumatized children: rage, betrayal, fear, resignation, defeat, and shame. In other words, the experiences matter. TLC has always approached trauma as an experience rather than a diagnostic category. The evidence-based *SITCAP* programs of TLC address what we found in 1990 and continue to find today to be the common experiences associated with trauma: fear, terror, worry, hurt, anger, revenge, guilt/shame, feeling unsafe, powerless, and engaged in victim thinking versus survivor/thriver thinking (Steele & Raider, 2001). This listing is more detailed than those found in the proposed DTD, but it is certainly inclusive of those criteria. *SITCAP* interventions are therefore directed at these primary experiences and themes within a developmentally appropriate context. The following

discussion of the Core Principle and Key Concepts is based on these early experiences with children, field testing, and evidence-based research that supports their value in the healing outcomes grieving and traumatized children have achieved.

Because trauma always involves significant losses, grief is part of the trauma experience (Levine & Kline, 2007). In subsequent chapters, we use the terms *trauma* and *traumatized children* with the understanding that we are also addressing the grief reactions inherent in the trauma response.

SITCAP's Core Principle

The core principle of the *SITCAP* model is that by providing children with the opportunity to safely revisit and rework the primary subjective experiences of trauma, within the sensory, not cognitive context in which they are experienced, stored, and remembered, PTSD symptoms and grief- and trauma-related mental health reactions can be significantly reduced, the gains sustained, and resilience developed and/or strengthened in ways that support growth.

We stated earlier that neuroscience has confirmed that trauma is experienced in the midbrain, where reason and logic—the ability to make sense of what has happened and act accordingly—simply are not accessible in trauma. Another way to explain how trauma is not primarily a cognitive experience is to examine memory processes, specifically the differences between *explicit* and *implicit* memory processes. Explicit memory, sometimes referred to as *declarative memory*, refers to primary cognitive processes in the neocortex region or the upper brain, also referred to as the left hemisphere. In explicit memory we have access to language; we have words to describe what we are thinking and feeling. Explicit memory allows us to process information, to reason, and to make sense of our experiences.

Such cognitive processes actually help us cope; however, trauma is experienced in implicit memory, sometimes referred to as the midbrain or right hemisphere, where there is no reason or language. There simply are no words to accurately describe or communicate what is being experienced. Positron emission tomography (PET) scans have found that trauma also creates changes in Broca's area of the brain, which leads to difficulties in identifying and verbalizing our experiences (Fosha, 2000; Van Dalen, 2001), a process that is normally accessible via explicit memory processes. In implicit memory, the traumatic memories are stored through our senses—what we see, hear, smell, touch, and taste (Rothschild, 2000).

If, therefore, there is no language to help children communicate what their experience is like, what matters most is that we present them with opportunities to communicate what it is like without words. The *SITCAP* process directs itself at actively involvng children in new experiences in order for them to build new neural networks related to

what they are learning about themselves and trauma as a result of the sensory-based activities they engage in when participating in *SITCAP*. The intervention process involves multiple sensory-based activities, which bring these sensory memories to life in a safe, contained context so they can be regulated, reordered, and reframed in ways that support a resilient response to future stressful, overwhelming, and terrifying experiences.

Point of Interest

SMAD!

While attending a recent conference, the presenter told a story about talking to a 4-year-old boy about labeling feelings. "Sometimes when we are sad, we cry and feel hurt, but at the same time we might be mad about something, too," is the statement that was told to the child. The 4-year-old responded, "Yeah, it's like being smad!"

Science supports this feeling, as described by the 4-year-old. In fact, Green, Whitney, and Potegal (2011) published a paper that details the patterned vocalizations that toddlers make during a tantrum. Sad sounds tend to occur throughout the entire tantrum, and on top of those sounds are typically sharp peaks of anger.

Learning the science behind a tantrum and understanding the pattern can help parents and professionals better respond to children. The stress that children experience when they have a tantrum shuts off the part of their brain that allows them to process, reason, and problem-solve. So, will asking children questions during tantrums help? Most likely the answer is no. It will make things worse, and the tantrum will ultimately last longer. Instead, stay with children through the peaks of anger, but don't try to reason with them. This means waiting through the screaming, yelling, kicking, pulling, and pushing without talking. The most important thing is to make sure they are safe. Once this peak is past, children will be left with sadness and will reach out for comfort. When this happens, comfort them with a hug, holding or sitting close beside them. Wait through the mad until you reach the sad!

Key Concepts

Subsequent chapters discuss in detail the ways neuroscience, resilience research and strength-based practices, and the key processes of trauma-informed care support these *SITCAP* intervention concepts.

Concept One: Safely Revisiting Subjective Experiences

Concept one is helping children safely revisit their traumatic experience(s) and/or work on those subjective experiences created by past exposures by focusing not on the trauma

experience itself but on how they are experiencing themselves, others, and the varied environments they are attempting to navigate daily, but doing so with the primal survival behaviors associated with trauma.

The following key processes reported in *Trauma-Informed Practices for Children and Adolescents* (Steele & Malchiodi, 2012, p. 96) are incorporated into *SITCAP* to support it as a safe intervention for children as well as the practitioner. They include the following:

- Introduce choice and control
- Use a structured approach
- Be a witness rather than an analyst
- Be curious and use open-ended questions
- Teach children to be mindful of the sensations associated with interventions
- Instruct children to stop anytime interventions become too activating
- Instruct children to stop us when what we are asking is too activating
- Follow the pace children set and practice titration
- Begin the session in a safe place and end in a safe place
- Help children recognize the pleasant and unpleasant sensations in their bodies, always resourcing those pleasant sensations when children are experiencing unpleasant, activating sensations
- Incorporate appropriate strategies according to principles of neurodevelopment
- Repeat interventions used to regulate or deactivate children's trauma-related reactions frequently in order to help them discover they have the ability to regulate those reactions
- Identify and involve at least one adult with whom children are familiar to reinforce what is learned
- Keep in mind that children always remain the best experts about what is helping and what is hurting

The *SITCAP* programs also address what children have consistently indicated as their common subjective experiences associated with trauma: fear, terror, worry, hurt, anger, revenge, guilt/shame, feeling unsafe, powerless, and engaged in victim thinking versus survivor/thriver thinking (Steele & Raider, 2001). Interventions are directed at these experiences and themes within a developmentally appropriate context. The structured drawing activities used in *SITCAP* give children a way to depict their subjective experiences while teaching us what matters most to them in their subjective worlds. Chapter 4 is dedicated entirely to this structured process.

Concept Two: Nonlanguage Activities

Concept two is using nonlanguage activities to help children convey the way they now see themselves, others, and us as a result of their past exposures, as well as using these

nonlanguage activities to reconstruct a view that assists in diminishing the survival-driven behaviors associated with trauma.

Remember that in implicit memory, traumatic memories are stored through our senses—what we see, hear, smell, touch, and taste (Rothschild, 2000). These memories are contained in "iconic symbols" (Michaesu & Baettig, 1996). *Iconic symbolization* is the process of giving our experiences a visual identity. Images are created to contain all of the elements of that experience—what happened, our emotional reactions to it, the horror-filled details, and the terror experienced. The trauma experience, therefore, is more easily communicated through imagery. "When a terrifying incident such as trauma is experienced and does not fit into a contextual memory, a new memory is established" (van der Kolk et al., 1996, p. 289). Stated differently, "When memory cannot be linked linguistically, in a contextual framework, it remains at a symbolic level and therefore there are no words to describe it. To retrieve that memory it must be externalized in its symbolic, perceptual iconic form" (Steele, 2003, p. 142).

In order to access this experience, what matters most is that we use sensory-based interventions, such as drawing, that allow children to actually make us a witness to their experiences, to present us with their iconic representations, to give us the opportunity to see what they now see as they look at themselves and the world around them following their exposure to traumatic experiences. In this sense, a picture is worth a thousand words, as shown in the Figure 1.1 drawing by an adolescent who was sexually abused multiple times.

Survival behaviors are formed, driven, and repeated because of how children experienced past traumatic situations and how they are experiencing their current situation, environment, and people in their environment. When they feel unsafe, threatened, or powerless, trauma-related survival behaviors emerge. When children are direct victims of repeated trauma, such as abuse, or exposed to multiple traumas, survival behaviors become more acute and include primitive, survival-directed fight, flight, and freeze behaviors, such as the following:

- **Fight behaviors** can include verbal attacks, aggressiveness, assaultive behavior, and defiance.
- **Flight responses** can include running away, refusal to talk, avoiding previous relationships and activities, dissociation, numbing out, substance usage and abuse, eating-disordered behaviors, depression, becoming suicidal, and engaging in other at-risk behaviors.
- **Freeze responses** can include being unable to make decisions or care for oneself, being lethargic, being nonresponsive, and being unable to interact or sustain relationships.

It makes sense from this perspective that when traumatized children are able to experience themselves, others, and the world, not as victims but as survivors, these

Figure 1.1 Sexual abuse

behaviors decrease. Such behaviors are difficult to diminish through talk-based therapies because they are driven by the way children are experiencing themselves and their worlds, not by higher-level thinking and problem solving. When we help children experience themselves differently, new behaviors emerge, as the practice outcomes and evidence-based research of *SITCAP* has demonstrated.

Concept Three: Using Trauma-Specific Questions

Concept three is using structured, trauma-specific questions to help children tell their story in ways that describe how they are experiencing each of the 10 major themes or subjective experiences addressed in the *SITCAP* model, such as feeling unsafe, powerless, and worried. These and their associated activities are described throughout the text.

The trauma-specific questions incorporated into the sensory process are very structured in order to address the major experience of the session being utilized, for example, the experience of hurt. The questions are not leading and do not ask about feelings, but they are in response to details given by the child. For example, if the child's response to the question "Where do you feel the hurt the most in your body?" is "in my stomach," then the follow-up question might be, "And what happens to your stomach when the hurt is at its worst?" This might be followed by, "Who or what makes the hurt go away?" These questions allow the intervener to remain curious and interesting to the child. At the same time, they help children work within a contained framework to safely elaborate the details of their memories and their experiences, to put their memories into a contextual framework. Once in a contextual framework, it becomes easier for children to begin to cognitively reframe their experiences in ways they can now manage. The specific questions and associated process are discussed in Chapter 5.

Concept Four: Being Curious

Concept four is remaining curious rather than analytical, following children's lead, and avoiding all interpretations, judgments, and assumptions about what they may need.

Children feel most comfortable when we take an interest in their worlds, when we are listening close enough to remain curious about what they tell us without being judgmental, interpreting their comments, or making assumptions. This is generally not an easy process initially for many professionals who were trained to be analytical, to think ahead, and to try to figure out the meaning of the information given by the child.

In TLC's certification training for Trauma and Loss Specialist, it generally takes two days of active participation for practitioners to become comfortable with being curious and imaginative rather than being in the "why?" mindset, which actually prohibits us from being attentive to children. For example, one child who saw his father kill his mother and was later kidnapped by his father only to witness further violence by his father and be left alone for long periods in a grungy room was asked, "What in that room let you feel the safest?" His response was "the couch." When we present this story in our training and then ask the participants what they would ask next, those who have not yet switched to being curious find it difficult to answer because they are too busy trying to figure out the meaning for themselves. Those who, at this point in the training, are able to be curious are quite spontaneous. In essence they follow up immediately with the question, "What about the couch made you feel safe?" Learning how to become a witness—curious rather than analytical—is important to the child's sense of safety and comfort with us and to the success of the intervention process. Being curious rather than analytical is addressed in greater detail in Chapter 5.

Concept Five: Safely Beginning and Ending

Concept five is beginning and ending each session in a safe place with interactions or activities children acknowledge are safe, comforting, and enjoyable.

Self-regulation, the ability to regulate one's reactions to stressful events and threatening situations, is a key component of trauma-informed practice (Hill & Updegraff, 2012; Linehan, Bohus, & Lynch, 2010). Self-regulation refers to the body-mind connection and the ability to use the body as a resource in healing. Stien and Kendall (2004) recommend that the body be used to involve new implicit memories in direct contrast to the traumatic experiences of the past.

> In work with chronically traumatized children in a residential setting, Ziegler (2002) finds that these individuals present with persistently activated arousal. By teaching the children to raise and lower arousal levels by inducing arousal reactions and then returning to a calm state, the children learned what to do with their bodies when faced with a threatening situation, and in so doing Ziegler notes that children became much better at self-regulation. (Steele & Malchiodi, 2012, p. 77)

When practitioners help children become aware of their sensory experiences, an integrated healing process begins. During the intervention process, we want to help children experience a sense of safety, a sense of calmness in their body before and following attention given to traumatic experiences. In essence, we want them to arrive at the conviction that "Even though my memories sometimes scare me and upset me, I will be okay because I can calm myself or deactivate activated reactions triggered by trauma memories" (Langmuir, Kirsch, & Classen, 2012). This concept is further discussed in Chapter 3.

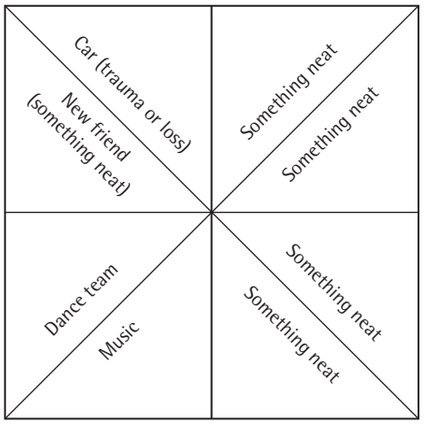
By beginning and ending in a safe place and attending to the trauma work in between, we are containing the trauma in a way that helps children remain safe but also gives them the opportunity to engage in activities that reinforce their ability to go to that safe place and regulate their responses when they are fearful.

Concept Six: Reframing the Experience

Concept six is delaying cognitive reframing until children reveal how they are now making sense of what they are experiencing as a result of the intervention.

Attempting to use language to help traumatized children heal while their predominant responses to daily life are from the midbrain, limbic region has very limited success. For children to accept our efforts to help cognitively reframe their experience and their view of self and others in ways they can now better manage, they must first experience that cognitive explanation at a sensory level. Cognitive reframing is important to healing

Figure 1.2 Trauma is only one part of my life



and is integrated into *SITCAP*, but only after being with children in sensory activities designed to support the desired cognitive explanations. Its use is discussed at length in Chapter 5; following is one example.

Using Figure 1.2 as a reference, create eight sections on a plain piece of paper. Now, going back in time, select one loss or trauma experience that is personal to you. Select a word or phrase that identifies that experience for you. If this experience was related to a car fatality, the word "car" might reflect that experience. Now write that word in one of the eight sections. Next, think about some of the fun, exciting, or interesting things that have happened in your life, and using the same process, select a word that reflects each of those experiences and write it in each of the remaining seven sections—put one fun experience in each section. It is sometimes helpful to provide simple examples, such as learning to ride a bike, some fun event at school, a friend, being on the dance team, or a vacation.

Now, as you look at the sections on your paper, what statement about you and trauma jumps out at you? The general response to this activity is that "Life is more than just trauma" or "Trauma is just one part of my life. There are many different parts of my life that make me who I am." This is a very simple activity and one we present in a variety of forms because it sets the foundation for moving from victim thinking to survivor thinking.

However, imagine a teen, whom we will call Martha, is in need of your help. Martha has experienced a horrible trauma, and you attempt to help her reframe her experience at a cognitive level without engaging in an activity that would help her arrive at this reframing by herself. For example, "Martha, what you've gone through is just horrific. I can't imagine what it has all been like for you, but what I need for you to understand and appreciate, Martha, is that this horrible incident is only one part of who you are. There are many parts, many facets of you—the many things about you that make you who you are today. Trauma does not change that about you."

Now how do you think your verbal effort is going to be experienced by Martha? When we present this verbal response in training, participants feel like we are minimizing her experience and, in so many words, saying "get over it." However, if you take Martha through the above activity, she will arrive at that conclusion for herself. Now your effort at reframing what she has arrived at through this sensory activity can be more easily accepted and integrated into her view of self. Cognitive reframing is very important to healing, but the reframing must reflect what has been experienced at a sensory level. Additional examples of the reframing process specific to the sensory experience are presented in Chapter 6.

Practice-Based Evidence (PBE) and Evidence-Based Practice (EBP) Outcomes

In this section we identify the essential research criteria needed to support an intervention's value. Although somewhat detailed, we find that an intervention will more likely be pursued and trusted when the criteria supporting its value are identified. The criteria address those interventions that have years of practiced history and documented, positive outcomes and those whose outcomes are the result of formal evidence-based research. *SITCAP* meets the criteria for both formal research and practice history.

It makes sense that an intervention be selected based on documented, desirable outcomes appropriate to the unique needs and characteristics of the population it is intended to help. Kasdin (2000) reviewed the existence of available intervention programs discussed in the literature. He identified 500 such interventions, but fewer than 10% had undergone any experimental research. For this reason, "The Society for the School of Psychology and various divisions in the American Psychological Association began developing mechanisms for validating interventions as evidence based in the mid-1990s" (Dietrich, 2008).

Dietrich (2008) suggests that an intervention that has a history of producing repetitive, documented desired outcomes is evidence of the value of that practice. Evidence-based practice, on the other hand, requires that desirable outcomes be reported by at least one empirically controlled study (APA, Presidential Task Force on Evidence-Based Practice, 2005). Today there still remains a great deal of discussion and varied differences in interpretation as to what constitutes practice-based evidence (PBE) and evidence-based practice (EBP). To avoid getting lost in the maze of researcher questions, challenges, and differences surrounding what constitutes valid evidence today, we present the following elements of an intervention that we believe make it of value to the practitioner and those children that intervention is intended to help:

- The intervention has proven useful in multiple settings with diverse cultures.
- The intervention has demonstrated, in varied settings such as schools and clinical settings, consistent documented outcomes over time (minimum of 10 years) with

varied treatment populations, such as children victimized by violent incidents as well as those exposed to nonviolent grief-inducing incidents.

- ➢ The intervention is practical, meaning it can be used by most practitioners as a group or individual process and is fairly easy to learn.
- ➢ The intervention is manualized to allow for greater practice fidelity so it can be accurately evaluated and appropriately used.
- ➢ The intervention has undergone at least one controlled empirical research study using an evidence-based research model, and has documented significant reduction of symptoms, in this case PTSD and related mental health symptoms.
- ➢ The intervention is based on well-researched, articulated findings involving neuroscience, resilience, and strength-based research.
- ➢ The intervention process is well accepted and supported by practitioners of various disciplines and by varied populations.
- ➢ The intervention lends itself to ongoing evaluation in multiple settings with diverse populations.

The *SITCAP* model meets all of these criteria. The model includes the following programs: *I Feel Better Now!* and *Structured Sensory Interventions for Traumatized At-Risk and Adjudicated Adolescents and Adults*. These programs cover children and adolescents from ages 6 through 18 and are designed for both group and individual intervention. Rather than providing a detailed statistical summary of their research history, which can be found in published studies (Raider & Steele, 2010; Steele, Kuban, & Raider, 2009; Steele & Raider, 2001; Steele, Raider, Delillo-Storey, Jacobs, & Kuban, 2008), we present a brief summary that supports the value of these programs based on the suggested criteria associated with PBE and EBP.

The *I Feel Better Now!* program was first field-tested in 1993 in 13 school districts and at three community agencies. A total of 150 children ages 6 to 12 completed this eight-session, sensory-based group intervention. The outcomes showed that 100% of the parents and each of the 80 practitioners providing the intervention recommended the program and saw significant changes in the children's behavior, even though the program did not focus on behavior but rather the subjective experiences induced by the children's grief and/or trauma exposures. Children were exposed to both violent and nonviolent situations, and the majority had multiple exposures.

In 2007 through 2008, *I Feel Better Now!* underwent additional formal evidence-based research involving 100 children in three different schools. Three standard assessment tools were used to evaluate outcomes between the treatment groups and waitlist groups, all groups at the beginning and end of the intervention program, and three months and six months later with no additional intervention. The Briere Trauma Symptom Checklist (Briere, 1966), the Achenbach Child Behavior Checklist (Achenbach and Rescorla, 2001), and the PTSD Child Questionnaire (Steele et al., 2009) all indicated statistically significant

Table 1.1 *I Feel Better Now!* Program Outcomes

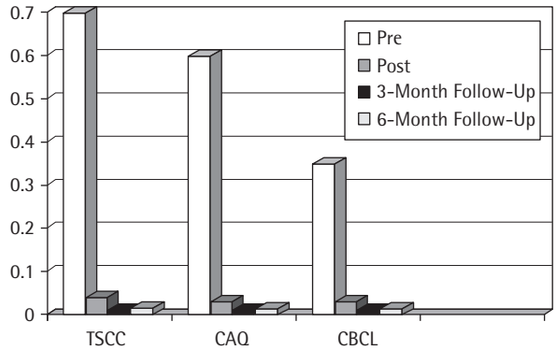
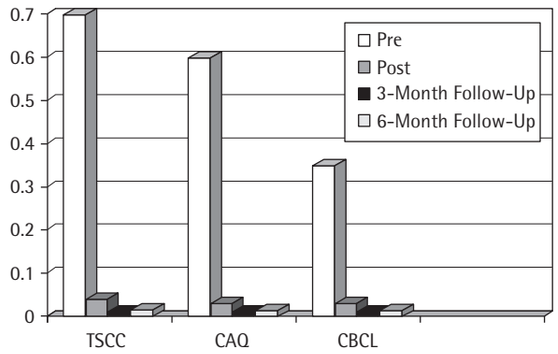


Table 1.2 At-Risk Adjudicated Adolescent Outcomes



reduction of PTSD and related mental health reactions at the end of intervention and at three and six months following the end of intervention, as illustrated in Table 1.1.

From 2006 through 2007, the adolescent program *Structured Sensory Intervention for At-Risk and Adjudicated Adolescents* underwent formal evidence-based research with at-risk and adjudicated adolescents in a residential setting. The same three standardized evaluation tools (adolescent versions) used to evaluate the *I Feel Better Now!* program were used in this controlled evidence-based research.

Table 1.2 presents the outcome of this evidence-based study. It demonstrates significant reductions in trauma-related and mental health–related symptoms at the end of intervention and three months following the last intervention. In addition, significant reductions were seen in anxiety, thought and attention problems, rule-breaking and aggressive behaviors, and internalizing and externalizing behaviors. Earlier studies by others of cognitive-behavioral interventions (Ovaert, Cashel, & Sewell, 2003) with

adjudicated adolescents did not demonstrate reduction in symptoms of anxiety, anger, and depression. It can be hypothesized that the combination of sensory interventions followed by cognitive interventions produced additional outcomes. Unique to this research was the use of an intervention Fidelity of Treatment Checklist completed for each participant. Results indicated 98.5% fidelity with the manualized treatment model.

Case Studies

In the two cases cited in Tables 1.3 through 1.6, the Youth Self-Report (Achenbach & Rescorla, 2010) and the Briere Trauma Symptom Child Checklist (Briere, 1996) were used to evaluate for PTSD and related clinically significant mental health symptoms prior to intervention, at the end of intervention (10 sessions), and again in three months. The following two cases illustrate the value of *SITCAP* for children and adolescents who are witnesses to violent, trauma-inducing incidents and for those who are the direct victims of traumatic experiences. Although these cases are specific to violence, the more detailed published outcomes of *SITCAP* research (Steele et al., 2008) show statistically significant reduction of symptoms in children exposed to single and multiple nonviolent and violent losses and trauma.

Repeated Abuse

Tables 1.3 and 1.4 show the significant reduction of trauma and mental health–related symptoms of 15-year-old Ruy who, over a long period of time had been abused,

Table 1.3 Case "R": Pre vs. Post Briere Trauma Symptom Checklist (TSCC-A)

Briere TSCC-A Scores	PRE	POST	3-MONTH*
Anxiety	9	2	1
Depression	14	3	3
Anger	22	5	4
Posttraumatic Stress	15	4	3
Dissociation	18	5	1

*3-month follow-up post-intervention

Table 1.4 Case "R": Pre vs. Post Achenbach Youth Self-Report (YSR)

Achenbach YSR Scores	PRE	POST	3-MONTH*
Attention Problems	8	4	4
Rule-Breaking Behavior	13	9	2
Aggression	13	11	3
Internalizing Behavior	15	4	3
Externalizing Behavior	26	10	1
Total Problems	**63**	**23**	**20**

*3-month follow-up post-intervention

Table 1.5 Case "S": Pre vs. Post Briere Trauma Symptom Checklist (TSCC-A)

Briere TSCC-A Scores	PRE	POST	3-MONTH*
Anger	9	2	2
Posttraumatic Stress	9	5	3
Dissociation	10	1	1

*3-month follow-up post-intervention

Table 1.6 Case "S": Pre vs. Post Achenbach Youth Self-Report (YSR)

Achenbach YSR Scores	PRE	POST	3-MONTH*
Social Problems	7	0	3
Thought Problems	12	6	2
Attention Problems	12	3	2
Aggression	12	2	2
Internalizing Problems	16	2	1
Externalizing Problems	18	9	1
Total Problems	**73**	**23**	**20**

*3-month follow-up post-intervention

neglected, and repeatedly raped before being removed from her drug-addicted parents. Although additional intervention was needed to especially assist her with socialization and developing relationships, posttraumatic growth became much easier with the reduction of PTSD and related mental health symptoms realized by engaging her in the sensory experiences of *SITCAP*.

Witness to Domestic Violence

Tables 1.5 and 1.6 show the significant gains made by Steve, a 12-year-old boy who witnessed the repeated abuse of his mother by his father and later his stepfather. Always living in fear of the next beating, Steve developed several trauma-specific and mental health–related symptoms, as shown in the above tables. He was failing in school and constantly fighting. By introducing him to new experiences via the *SITCAP* intervention, his view of self, others, and life changed, and his trauma-related behaviors diminished significantly.

Summary

The 23 years of practice- and evidence-based research supports the value of *SITCAP*. What makes this set of programs unique is its focus on attending to how children are experiencing their life, the use of structured sensory activities to reduce PTSD and related mental health reactions, its use with violent and nonviolent grief- and trauma-inducing experiences, and its use in multiple settings with diverse populations. We introduced this chapter with the mandate from grieving and traumatized children, and discussed that

what matters most are not their symptoms but how children are experiencing themselves, others, and life as a result of exposure to grief and/or trauma-inducing incidents.

This approach is such an essential part of the *SITCAP* process that in Chapter 2 we expand on its importance to children and practitioners. We present Alicia's story to illustrate that a diagnosis does not necessarily tell us what is going to matter the most in our efforts to help children. After describing some of the differences between grief and trauma, we examine how children's experiences shape their private logic and their thoughts about self and others, and how these induce trauma-driven, survival behaviors. The chapter then concludes with the rationale for incorporating sensory-based experiences into the *SITCAP* programs.