One-Minute Interventions

FOR TRAUMATIZED CHILDREN AND ADOLESCENTS

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STARR COMMONWEALTH

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COA Council on Accreditation

BBB ACCREDITED CHARITY bbb.org

2019 PLATINUM

About the Authors

Caelan Soma, PsyD, LMSW, ACTP, Starr Chief Clinical Officer, provides trauma assessment and short-term trauma intervention for students utilizing trauma-informed and evidence-based practices, including Starr's SITCAP® model.

Dr. Soma has been involved in helping with the aftermath of disasters such as Sandy Hook, Hurricanes Katrina and Rita, 9/11 and more. She has authored several books, the most recent titled *Working with Grieving and Traumatized Children and Adolescents*.

She is an internationally acclaimed speaker and trainer, and is the instructor for many Starr courses, including Children of Trauma and Resilience and Structured Sensory Interventions II. She received her doctorate in clinical psychol-ogy at California Southern University, where she also received the 2013 CalSouthern President's Award.

Dr. William Steele, PsyD, MSW, founded the National Institute for Trauma and Loss in Children (a legacy program of Starr) in 1990, long before children were included under the diagnostic category of Posttraumatic Stress Disorder (PTSD). He began his trauma work with children over 38 years ago. In the early 1980's his program, *Preventing Teen Suicide*, won a Michigan Emmy as Best Children's Program. He assisted hundreds of school dis-tricts with developing crisis teams and suicide intervention strategies at a time when those were non-existent in most schools. He was one of the first Americans invited by the Kuwait Social Development Office to train it's staff in ways to help their traumatized families following the Gulf War. He was one of only 70 professionals world-wide invited to participate in the Interna-tional Assembly on Managing the Psychology of Fear and Terror.

Due to Dr. Steele's efforts over 60,000 professionals have participated in Starr trainings and special projects. However, he is most proud of the 5,000 professionals he has personally trained and certified as Trauma and Loss Specialists and Consultants now providing his evidence-based trauma-specific intervention programs to thousands of children and families across the country. Author of numerous books, articles, materials and intervention programs, his greatest joy is hearing the stories of the children who have found relief and peace and have begun to thrive as a result of the Starr interventions.

Dr. Steele's passion has been to increase accessibility to these interventions for traumatized children and families. This keeps him in high demand for training and consultation, especially with today's focus on trauma-informed care. What others say about Starr reflects his gift of being able to bring timely, practical, outcome-driven trauma-specific "tools" to helpers in all settings.

About Starr Commonwealth

Starr Commonwealth provides in-person training, materials and resources, and eLearning to educators, clinicians, and other professionals that equip them with the latest tools and practices to help heal the effects of trauma and build resilience in children.

From educating professionals to healing through direct services, Starr Commonwealth is driven to heal while leading with courage for systems-level change to address one of the most important mental health crises our nation faces today.

www.starr.org

Introduction

Starr has developed *One-Minute Interventions for Traumatized Children and Adolescents*, a collection of age-specific, sensory-based trauma intervention activities to use with children and adolescents when time is limited. All intervention activities take less than 20 minutes to complete and many can be done in 5 or 10 minutes. These new activities are based upon Starr's evidence-based research that supports the effectiveness of sensory experience followed by cognitive reframing when facilitating trauma intervention. These activities, based upon the principles of trauma-informed care are essential to include in today's school, agency and residential child care environments. Please read the article, *Trauma Informed Care*, that follows this introduction, written by Dr. William Steele, the founder and director of TLC, for a comprehensive summary of Lessons Learned when providing trauma-informed care to children and adolescents in both group and individual settings.

When a child or adolescent experiences a trauma, arousal is the neurophysiologic response. A traumatized child or adolescent's predominant processing of trauma occurs and is stored in the mid and limbic areas of the brain, which deal with non-verbal information (Perry & Szalavitr, 2006). Trauma is processed to a lesser extent in the neocortex area of the brain that involves reasoning, linear thinking, analysis, and the ability to make sense of the experience. The child or adolescent who remains or is frozen in a state of arousal due to past or current trauma has difficulty using cognitive processes. This happens when the stress hormones released during arousal impact the part of the brain responsible for these processes. For example, in an aroused state, it is difficult to process information, make sense out of one's trauma experience, and identify and verbally express one's emotions. Memory and the ability to attend, focus and retain information are also diminished. These cognitive deficiencies suggest the need for non-cognitive approaches to help children overcome or minimize the learning, emotional, and behavioral problems resulting from the traumatic arousal.

Sensory-based therapeutic activities therefore are necessary to assist with the processing of the implicit memories of trauma and to restore more effective emotional functioning. When more effective emotional functioning is restored, cognitive/behavioral therapeutic activities can more effectively develop clearer thinking and positive coping strategies.

One-Minute Interventions for Traumatized Children and Adolescents, a collection of

age-specific, sensory-based trauma intervention activities, utilizes drawing activities and trauma specific questions that target the major sensations which are experienced in a traumatic event (e.g., anger, fear, hurt, worry, powerlessness). Traumatic memories are experienced at a sensory level and must be reactivated in a safe environment in order to be moderated and tolerated with a sense of power and feeling of safety. Because trauma is a sensory experience the memory is often stored symbolically. Images–how children and adolescents look at themselves and the world around them–defines what the trauma was like. This is why Starr relies heavily on drawing as an intervention medium. Children and adolescents can't just be told they are safe, because telling them happens on a cognitive level and is an explicit or outer-brain function. They need to feel safe on a sensory level to restore the functions of the deep brain and subsequently give them the ability to respond appropriately to future stress and/or crisis.

Like all of Starr's programs, *One-Minute Interventions for Traumatized Children and Adolescents* focuses on major experiences, sensations, and themes of trauma. The activities, therefore, do not attempt to treat behavior, but rather the sensory experiences of trauma that fuel and drive behavior. van der Kolk (1996) identified worry about the safety of a family member or friend following an incident as one of six factors involved in the complexity of a child's reaction to trauma. Questions about worry for the safety of loved ones, the families of the deceased child and injured children, and about personal safety are helpful to ask. It is also helpful to identify the nature and level of severity of the child's primary worry early in intervention and then again at the end of intervention to determine the status of the child's worry. In field tests and research conducted by Starr, the level of worry severity at the beginning of intervention frequently corresponds to the overall level of severity of all reactions. Changes in worry at the conclusion of intervention also correspond to changes in severity of all other reactions following intervention. If worry is significant typically the level of the severity of reactions across all subcategories of the *DSM-IVR* PTSD diagnostic criteria, re-experiencing, avoidance and arousal, are significant as well.

Hurt following trauma is frequently experienced physically, but often goes unattended especially when the trauma did not involve any form of injury or physical assault to the child. Activities that address a child's perception of where the victim/witness felt the hurt the most, such as in one's chest, head or stomach, are helpful. Often somatic complaints, such as

stomachaches and headaches need to be addressed from a trauma perspective. Asking the child to draw with the aid of trauma specific questions like, "What does your hurt look like?" "Where does the hurt live in your body?" and "What about the trauma hurt the most?" are all questions that help the intervener to witness the child's hurt at a sensory level.

At the core of trauma-driven anger is a sense of powerlessness. Helping children externalize their anger safely into a trauma container (an 8.5" X 11" sheet of paper) and giving them the opportunity to tell their story surrounding the anger allows them to reorder their experience in a way that is manageable, and brings relief. The focus on anger is also a natural introduction to the presence of guilt, also a face for powerlessness.

The *DSM-IVR* (APA) identifies the absence of future orientation as a criterion of PTSD. Those who are unable to make the shift from relating to life as a victim versus survivor have been unable to reconnect themselves to the future. Loss of future orientation is also related to suicide. Re-connecting the child to a future is paramount to healing. Activities that focus on seeing oneself as a survivor and then engaging life as a survivor, is about rebuilding hope for the future and experiencing a renewed sense of power to "protect" oneself in the face to future trauma. Although cognitive reframing is an important process, hope still must be "known" at the sensory level in order to trigger the energy to act on behalf of ones own life. Activities that allow children and adolescents to list events and move those events in an upward motion is a sensory way of experiencing, "life in forward motion" and coming to "know" that despite what has happened, he is surviving. This "survivor thinking" can then be reinforced cognitively by the intervener but more often by the child who begins to see his life differently as it is "mapped out" in front of him.

Cognitive reframing is scripted in *One-Minute Interventions for Traumatized Children and Adolescents* to insure that the victim is provided a "survivors" way of making sense of their trauma experiences. The goal is to help move participants from "victim thinking" to "survivor thinking" which leads to empowerment, choice, and active involvement in their healing process and a renewed sense of safety and hope. However, keep in mind that the child can only accept such reframing when their sensory experience validates the reframing.

Activities also assist in supporting the reframing of the experience in ways that are more manageable for them. Therapies that engage "explicit" cognitive processes are likely to be ineffective when traumatized adolescents are in the state of intense fear or terror. Steele (2003),

Stein & Kendall (2004) and others now agree that children and adolescents must re-experience a sense of safety from and control (regulation) over those reactions induced by trauma before they can actually engage those explicit processes which are needed for cognitive re-structuring - the reordering of the experience in a way they can now manage; in a way that this memory now becomes a resource versus a memory to be avoided. For example, "Your experience has left you worried about what might happen next, this is certainly normal, but keep in mind, no storm comes to stay forever, your worry will in time also leave."

Case Example

The following is a brief case study that illustrates the importance of providing every client we see with a trauma-informed assessment followed by trauma-informed intervention to ensure the best outcome possible.

We will refer to this client as "C". "C" was a 12-year-old female admitted to a residential center in 2006. She was removed from an abusive home in 2002. Parental rights were terminated and she was made a ward of the state. "C" had been placed at 5 other locations prior to this residential setting and all five reported the same consistent problems–severe temper tantrums, self-abusive behavior and physical aggression including biting. She had 5 different diagnoses–ADHD, Bipolar, Oppositional Defiant and Reactive Attachment Disorder. Several medications had been prescribed. Obviously, this made it difficult for to know what might be best for this youngster while in our care.

In the first month, our observations revealed that "C' had a very low frustration tolerance level, with no boundary controls. She often screamed when upset and would physically attack and bite those who tried to intervene. She was in the 4th grade but unable to remain in school for a full day. When communicating "C" frequently debased herself with statements like, "I'm stupid".

Staff approached "C" as a twelve year old who should be able to follow direction and interact with even a few of the adults and other children in her cottage. However, "C" frustrated everyone by her behavior and inability to follow instructions. She was continually placed on restriction, repeatedly lost her privileges and was being considered for placement in a more secure setting. Without trauma-informed assessment, our only view of "C" came from observing her behavior. They only told us she was troubled – not what triggered these behaviors; not what this traumatized child needed. Our trauma-informed assessment process gave us an entirely different view of "C'. The trauma-informed assessment drastically changed the staff's response to her. It also changed "C" and allowed her to stay at the residential setting for several months before successfully being returned to her uncle in a less restrictive environment. Briefly our assessment revealed that "C's" thinking and reasoning ability was only better then 2% of children her age. What did this mean? It meant that "C" would not be able to keep up with others her age in many situations requiring appropriate thinking and reasoning. Her reading and comprehension were only at the first grade level. This was a 12-year-old function-ing as a 6-year-old girl.

This view showed us that “C” would find it very difficult to understand any written communication, communicating well with others, or be able to makes sense out of verbal communications directed to her. She had poor short term memory and for “C’ –little made sense–one plus one did not equal two for her. Furthermore, her own self-assessment only indicated minor problems. Basically, “C’s” cognitive processes were that of a traumatized brain. Trauma neurology has emphatically determined that traumatized children’s brains become cognitively underdeveloped while their “midbrain”, the “survival brain”, always is ready for something else to happen. Thus it becomes the dominant way traumatized children try to survive in their environment. They run, bite, attack, hide, or do whatever is necessary when they perceive change/danger whether that change/danger is real or not. The staff learned that “C’s” reactions were not in response to something they had done incorrectly, but in response to her inability to makes sense out of everything and everyone in her environment. They learned that they needed to relate to her as a 6 year old, not a twelve year old. The best way to relate to her was by using visual forms of communication versus words or written communication.

“C” was given the choice of two people on campus that she could run to if troubled. Rather than trying to restrain her, the staff (now being trauma-informed) could respond to her behavior as a need for safety not as an attempt to defy or manipulate them. Staff was no longer restrictive and frustrated. Within two months, the running, biting and other behaviors seen as oppositional and defiant were now almost nil. By working with her using visual story-boards and scripts,“C” actually began to interact more appropriately with the children in her cottage. She was given recreational and physical activities appropriate for a six year old. She began to have fewer episodes during these activities. Her attention span had also been in-creased. When she was discharged, “C” was a different child, not out of control, not isolated. Of course, we shared with the legal guardian the same information we learned and how best to respond when “C” was having a difficult time.

Ages 3-5

SAFETY

Keep this Kitten Safe!

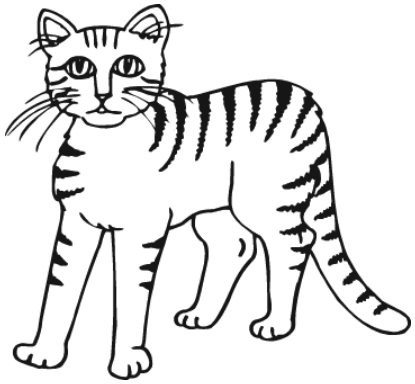
Directions:

Ask the child to draw in what this kitten needs to feel safe. If the child needs help getting started suggest that the kitten might like to have a blanket or toy near them.

Reframing:

All of us have certain things or people in our lives that make us feel safe. This kitten needs _____ to feel safe. What things or people do you need to help you feel safe? Why do those things make you feel safe? Why does that person make you feel safe? Listen and acknowledge their responses.

Keep this kitten safe!



SAFETY

Safe Place

Directions:

Ask the child draw a picture of their safe place. If the child needs help getting started suggest certain places that may feel safe to them i.e. bedroom, grandma's house, school. Encourage them to draw in all of the things about that place that makes it feel safe.

Reframing:

Yes, we all have certain places where we feel most safe. It is a good feeling to feel safe isn't it? Feeling safe makes us feel happy. If you can't go to your safe place you can always draw a picture of your safe place to remember what it feels like to be there!

My safe place:

Ages 6-12

WORRY

Late at Night when Everyone is Sleeping, I'm Awake Thinking About...

Directions:

Ask the child what they worry about the most. If the child needs help ask questions about Family, Friends, School etc. Then have them write their worries in the thought bubble and color in the drawing.

Reframing:

When it rains it doesn't rain forever, does it? NO. Worries don't last forever either. Some worries seem like there is nothing we can do to change them or stop them. But we can't do anything to stop the rain either, but it stops doesn't it? YES. And when it rains don't we usually find something to do until it stops? Sure we do.

What I worry about:

WORRY

Worry Beads

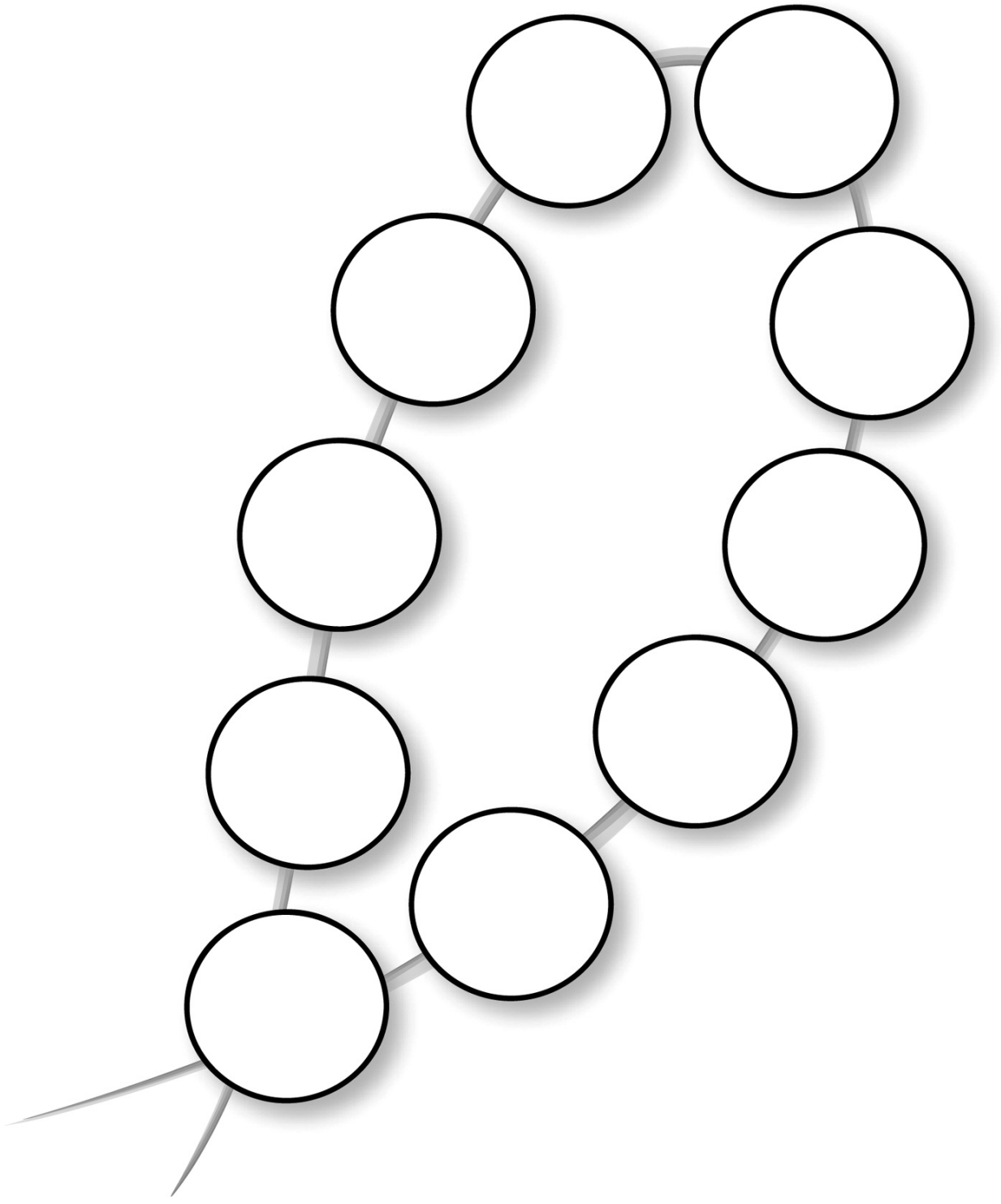
Directions:

Ask the child to list one of their worries on each bead. Then ask them to color in the beads that represent their biggest worries.

Reframing:

Now that your worries are listed on each bead, you can keep this paper in a private place in your bedroom. Instead of keeping all of those worries in your mind, they are right here on this paper. If one of your worries goes away you can cut that worry out of your picture. Or, if you want me to keep your paper here I can keep it safe and we can cut out the beads together as your worries go away.

List one worry on each worry bead. Color in your biggest worries.



Adolescents 13-18 Years Old

HURT

This is Where I Feel the Hurt Most in My Body

Directions:

Ask adolescent to color in the part(s) of their body that experiences that hurt.

Then ask the following questions:

Describe the hurt. What is it like to you?

If the hurt could talk, what would it say?

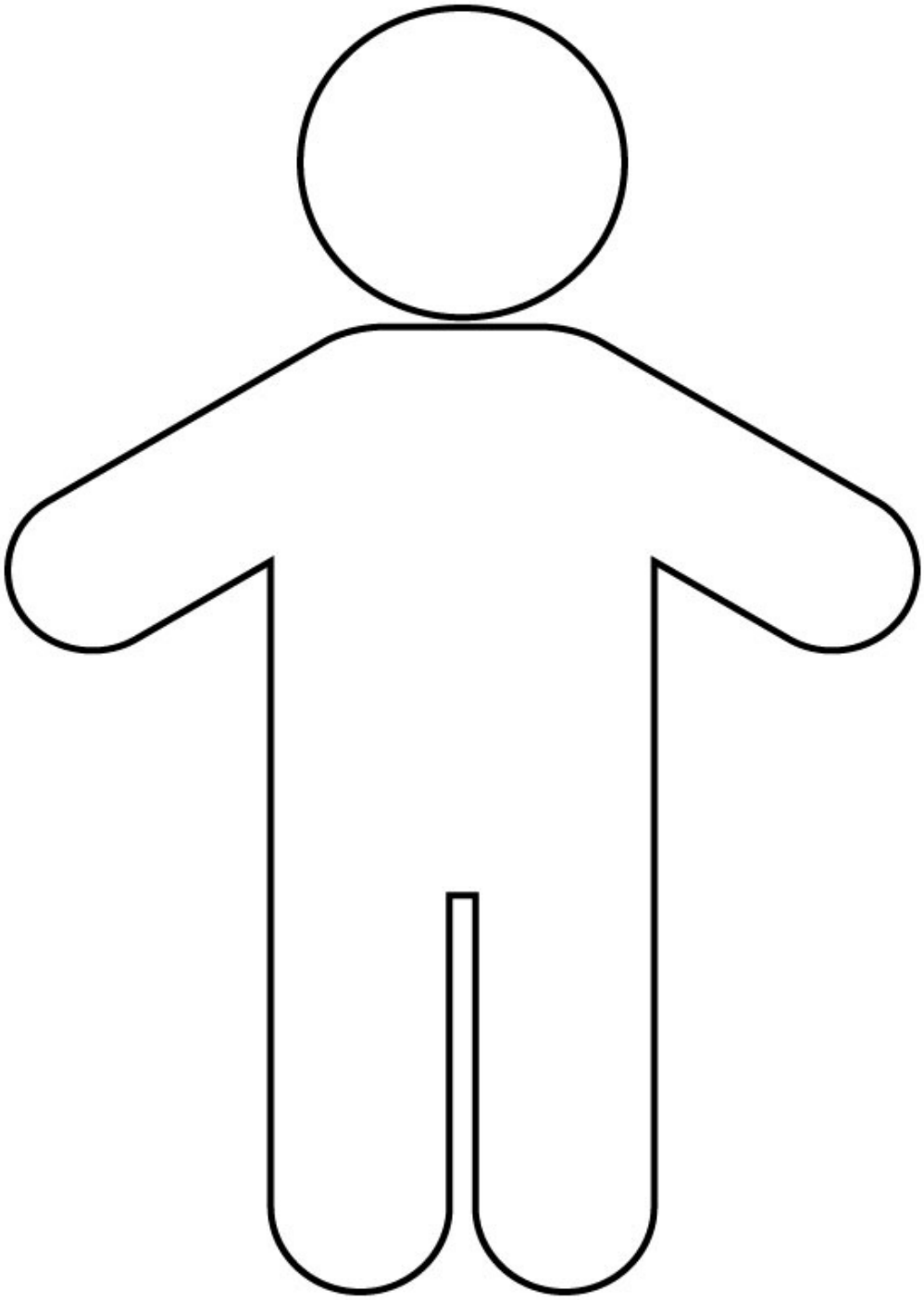
If the hurt could listen, what would you say to it?

If the hurt had a name, what name would you give it?

Reframing:

Gaining control over hurt is a process that takes time. Identifying what you are feeling, talking about it, making drawings and images of what these feelings are like for you are important steps in gaining control over your hurt. In time, your hurt will become less painful.

This is where I feel the hurt most in my body:



HURT

If my Friend Feels Hurt I Would Help Them By...

Directions:

Ask the adolescent to list the things they would do for a friend or say to a friend who was experiencing hurt.

Reframing:

You can do and say these same things to yourself when you are feeling hurt. You are your own best friend!

If my friend feels hurt I would help them by:

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starr.org/one-minute