THE BODY KEEPS THE SCORE

HEALTH PROBLEMS IN FAMILIES WITH DOMESTIC VIOLENCE

- CHILDREN LIVING IN HOMES WITH DOMESTIC VIOLENCE USE HEALTH SERVICES SIX TO EIGHT TIMES MORE OFTEN THAN CONTROLS
- WOMEN EXPERIENCING DV MORE LIKELY TO :
  - DEFINE THEIR HEALTH AS POOR
  - HAVE BEEN DIAGNOSED WITH STDs AND OTHER GYNECOLOGIC PROBLEMS
  - SAY THEY NEEDED MEDICAL CARE BUT DID NOT GET IT
  - HAVE TWICE THE NUMBER OF DAYS IN BED DUE TO ILLNESS THAN OTHER WOMEN

TRAUMATIC VIOLENCE THE PERSISTING STATE OF FEAR (Perry)

- Children growing up in an environment that requires a persistent `"fight or flight" state develop a hypereactive central nervous system (in the brainstem and midbrain) marked by:
  - hypervigilance, impulsivity, cognitive distortions
  - focus on non-verbal cues of threat ultimately resulting in V-P split marked by non-verbal (i.e. aggressive) approach to problem solving
- Persistent physiologiclal hyperaarousal and hyperactivity reflected in:
  - increased muscle tone, sleep disturbance and abnormalities in cardiovascular regulation
    - abused boys exhibit marked tachycardia during interviews about their traumatic experiences, girls show decrease in pulse rate- mirrored in higher CD rates in abused boys and withdrawn/dissociative defenses in abused girls

Screening Questions in Health Care Settings

- One quarter of women using emergency departments have a history of partner violence in previous year
- Women more likely to reach out for help to health care rather than mental health professionals
- Three questions that will detect two thirds of abused women
  - Have you been hit, kicked, punched or otherwise hurt by someone in the past year?
  - Do you feel safe in your current relationship?
  - Is there a partner from a previous relationship who is making you feel unsafe now?

Pediatrician Screening

- Are there places on your body where other people should not touch you?
- What do you call those places? Or can you point to those places?
- Has anyone ever touched you there?
- Discuss the areas that are not to be touched and who or when another can touch their private parts

Only One in Five Victims Disclose Promptly

- Between 60-80% of children withhold disclosure of sexual abuse until adulthood

Alaggia, J Can Acad Child Adolesc Psychiary (2010) 19:32

- Mean delay from 3-18 years
- 20% never disclose

People Whose Voices Aren't so Easily Heard

- Invisible communication
  - Clever Hans
  - Pygmalion
- Example of sexual abuse victim whose mother went to room to put away clean laundry while she was being abused
- Children who tell parents or teachers about abuse only to be met with glazed stares and a change of subject
- Child of DV example

II: Does it Help or Hurt to Talk to Children About Traumatic Events?

Timing of Talking

- How can and should we talk with children who have experienced abuse or other trauma?
- Could we do damage by talking?
- What sort of talking or listening is most helpful?

Variability in Coping Styles and Timing of Directly Addressing Issues

- Coping rooms
- Cochrane review on timing
  - Example of girl abused by swimming coach
  - boy who witnessed father murder mother
  - Holocaust survivor literature- example of Israel and Rwanda

One Size Doesn't Fit All

- In study of patient preference for physician style in breaking bad news
  - 77.8% preferred an "empathic professional"
  - 12.5% preferred a "distanced expert"
  - 9.7% an "emotionally burdened expert"
  - Older patients, those with an external health locus of control, lower education were more likely to be in the 22% that did not prefer an empathic professional

Martins, R. (2013) Breaking bad news: Patient preferences and health locus of control, Patient Educations and Counseling, 92:67-73.

Name the Monster

- Power of "lighting up Broca's Area"
- Review by Roth that found that active verbally mediated coping mechanisms seem to be most adaptive over the long-term

Need to Check for Understanding: Discrepant Communication Between Health Care Professionals and Families

- Physicians often incorrectly interpret an absence of patient/family questions as the patient not wanting to know about prognosis
  - Global tendency to underestimate information needs of patient and their family particularly in light of high level of confusion regarding emotionally laden information
- A substantial percentage of patients believe that palliative therapies are curative

Hancock, K. et al. (2007) Discrepant perceptions about end-of-life communication: A systematic review, Journal of Pain and Symptom Management, 34, 190-200

III: What should we do when parents don't want us to talk with or listen to children?

- CHOP research on importance of congruence between parental and child perception of pain
- Power of psychoeducation of parents
  - Chicken pox analogy
  - Cleaning wound analogy
- Engagement literature: To be understood first understand

- MEDICAL TRAUMA AND COMPLEX PTSD

DEVELOPMENTAL ISSUES

- PRESCHOOL CHILDREN TEND TO RESPOND TO TRAUMATIC EVENTS BY MANIFESTING GLOBAL, DISORGANIZED REACTIONS, TRAUMA SPECIFIC FEARS, REGRESSION, CLINGINESS OR IRRITABILITY
- LEVEL OF PRESCHOOLER'S DYSFUNCTION IS HIGHLY CORRELATED WITH LEVEL OF PARENTAL DISTRESS
- SCHOOL- AGE WITNESSES MORE LIKELY TO RESPOND WITH SOMATIC CONCERNS, SLEEP DIFFICULTIES AND SCHOOL PROBLEMS

DEVELOPMENTAL CONSIDERATIONS: PRESCHOOLERS

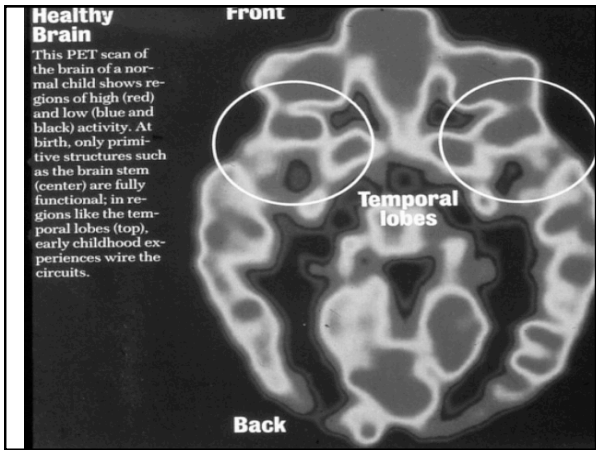
- Most have difficulty understanding the reason for parental fighting which may be viewed as their fault, or punishment
  - may blame victim rather than perpetrator, because “might makes right”.

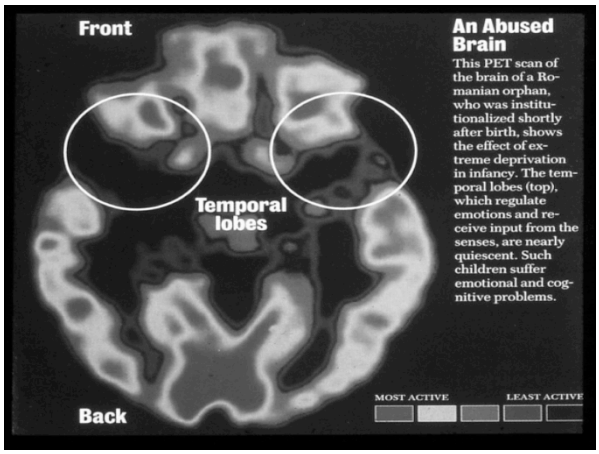
DEVELOPMENTAL ISSUES: ADOLESCENT WITNESSES

- ADOLESCENT WITNESSES ARE AT RISK FOR ENTERING ABUSIVE RELATIONSHIPS WHILE DATING
- RELATIVELY MILD BEHAVIOR PROBLEMS OF PREADOLESCENCE MAY GIVE WAY TO MORE SERIOUS HIGH RISK BEHAVIORS E.G. RUNAWAYS, EARLY PREGNANCY OR MARRIAGE
- EXPOSURE TO TRAUMA IN ADOLESCENCE CAN BE PARTICULARLY DAMAGING STUDIES OF VIETNAM VETERANS AND RAPE VICTIMS FIND HIGHEST RISK IN ADOLESCENT VICTIMS

ALTERATIONS IN AFFECT AND IMPULSE REGULATION

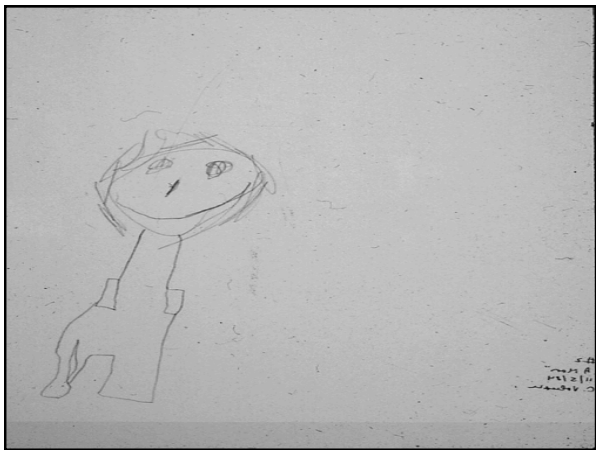
- Chronic and pervasive depressed mood or sense of emptiness or deadness
- Physically self destructive acts e.g. self mutilation
- chronic suicidal preoccupation
- Over inhibition of anger or excessive expression of anger
- Over inhibition or excessive expression of sexual drive e.g. lack of sexual drive following rape, promiscuity following sexual abuse
- Excessive risk taking associated with persistent feelings of invulnerability

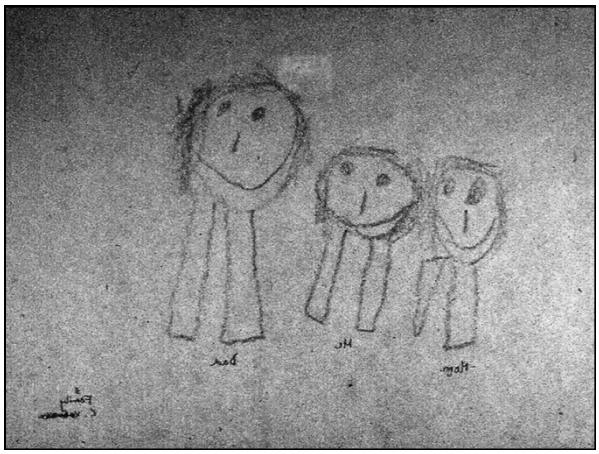




ALTERATIONS IN RELATIONS WITH OTHERS

- Inability to trust or to be intimate with others
- Increased vulnerability to being revictimized by a different perpetrator
- Victimizing others in the same way that one was victimized





ALTERATIONS IN SELF-PERCEPTION

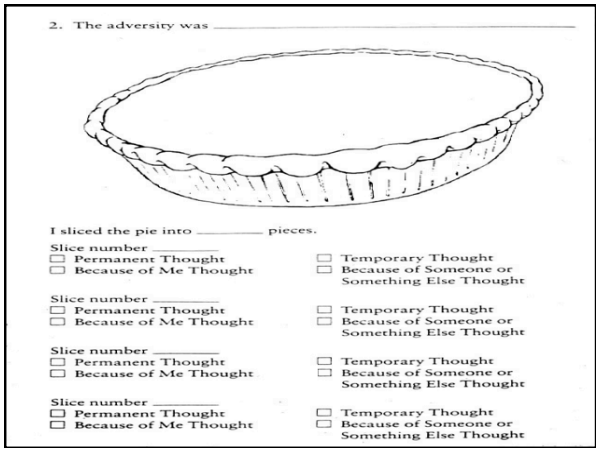
- A generalized sense of being ineffective in dealing with one's environment that is not limited to the traumatic experience - ranging from lack of confidence in one's own judgement to total immobilization.
- The belief that one has been permanently damaged by the stressor
- Exaggerated sense of guilt or responsibility for the trauma
- Persistent shame, embarrassment, or humiliation regarding others' knowledge of the traumatic experience
- The feeling that nobody else can understand the traumatic experience
- Inappropriate minimizing of the injuries that were inflicted by the stressor

A FAILED PREVENTION EFFORT

- 19 children saw a prevention film while they were being abused
- 10 remembered seeing the film, but only 3 recalled details
- none of the children acted on what they were told to do in the film
- Reasons given for film not being helpful
  - Abuser was not shown in the movie
  - Fear that parents would blame them for "participating" in sexual games
  - Threats were too frightening - Children felt overpowered by abuser

DEALING WITH SELF BLAME

- Characterological as opposed to behavioral self-blame is associated with feelings of worthlessness and guilt
  - Presented to child as "because of me" thoughts as opposed to "because of someone or something else"
    - these thoughts should not be presented as "good" or "bad"; emphasis should be on discovering pattern and consequences
- Explain personalization, give hypothetical examples, "because of me" vs. "someone else", and real life ABC's
  - Pie Game: helpful for children who think in "black" or "white" ; Draw pie with different slices labeled by child with a variety of "causes" of the problem, identifying the multiple causes allows for more effective problem solving, practice having child label each slice on dimension of "because of me" vs. "because of others"


2. The adversity was _____

I sliced the pie into _____ pieces.

Slice number _____
☐ Permanent Thought
☐ Because of Me Thought
☐ Temporary Thought
☐ Because of Someone or Something Else Thought

Slice number _____
☐ Permanent Thought
☐ Because of Me Thought
☐ Temporary Thought
☐ Because of Someone or Something Else Thought

Slice number _____
☐ Permanent Thought
☐ Because of Me Thought
☐ Temporary Thought
☐ Because of Someone or Something Else Thought

Slice number _____
☐ Permanent Thought
☐ Because of Me Thought
☐ Temporary Thought
☐ Because of Someone or Something Else Thought

HOW TO MAKE YOUR CHILDREN SAFER (ABA Guidelines)

- **Teach them not to get in the middle of a fight**, even if they want to help
- **Teach them how to get to safety**, to call 911, to give your address & phone number to the police
- **Teach them who to call for help**
- **Tell them to stay out of the kitchen**
- **Give the principal at school or the daycare center a copy of your court order**; tell them not to release your children to anyone without talking to you first; use a password so they can be sure it is you on the phone; give them a photo of the abuser
- **Make sure the children know who to tell at school if they see the abuser**
- **Make sure that the school knows not to give your address** or phone number to ANYONE

PTSD in Parents of Children with Cancer

- Research has consistently documented that parents of children with cancer are at greater risk for PTSD then are their ill child
- Controlled study of 309 children off active treatment found 10% of mothers and 7% of fathers as experiencing severe post traumatic symptoms Posttraumatic stress, family functioning, and social support in survivors of childhood leukemia and their mothers and fathers. Kazak, Anne E.; Barakat, Lamia P.; Meeske, Kathleen; Christakis, Dimitri; et al
Journal of Consulting & Clinical Psychology. 1997 Feb Vol 65(1) 120-129

Re-experiencing

- Upsetting memories of what happened come into your mind when you don't want them to
- Nightmares about what happened
- High levels of upset or agitation when something reminds you of what happened

Psychoeducation: The Power of Information and Perspective

- Chicken pox analogy
- Story of delayed reaction in woman who was assaulted
- The boy with 17 strikeouts

Avoidance and Numbing

- Avoid people, places or situations that remind you of what happened
- Feel emotionally "flat", like you are trying to avoid having any feelings at all
- Feel distant from friends and family and find it difficult to trust anyone
- Feel different from other people, like nobody really understands you

Treatment of PTSD: Psychoeducation: Avoidance

Bryant, R. & Harvey, A. Acute Stress Disorder, American Psychological Association Press, Washington, DC, 2000

- *"It is very common after a trauma to avoid all thoughts and reminders of the trauma. People often do this because thinking about it is so distressing that it seems much better to put it all aside. This makes you feel better for a moment but this sort of avoidance can actually prevent you from getting over the experience"*
  - *"One of the ways that people try to avoid the distress associated with the trauma is to block the feelings that they have about it. People can feel emotionally flat or detached from things. Sometimes people feel like everything is strange or dreamlike. This happens because you are distancing yourself from what happened. It is a way of turning your back on the whole experience. This reduces the distress in the short tem but eventually gets in the way of resolving this experience because it doesn't allow people to connect with and resolve what they have been through"*

Hyper-arousal

- Irritable or on edge much of the time
- Get angry easily
- Find it hard to attention at work or remember what you have read
- Trouble sleeping
- Startle easily

MOTHER AND CHILD PTSD STATUS IN ADOLESCENT CANCER SURVIVORS

- All of the cancer survivors who had current PTSD had also had mothers who had current PTSD
- 83% of the cancer survivors who had lifetime PTSD had mothers with lifetime PTSD
- If a mother had current PTSD in response to her child's cancer , her child was seven times more likely to develop PTSD than if the mother did not have PTSD Pelcovitz et al (1996 PTSD in mothers of pediatric cancer survivors, Psychosomatics, 37: 116-126

A Unique contributor to Traumatic Stress: Parents intervene frequently in their child's treatment

Parental intervention in the medical care of children with cancer
Lozowski, S; Chesler, M; Chesney, B.
Journal of Psychosocial Oncology. 1993 Vol 11(3) 63-88

- Study of 116 parents of children with *cancer*, 56% reported intervening at some point in the treatment process to prevent or correct a medical mistake.
  - (1) prevent or correct erroneous administration of drugs,
  - (2) remind the staff of correct or incorrect procedures,
  - (3) alter intravenous procedures
  - (4) mediate the staff's style of interacting with ill children.
- Parents with fairly high levels of income and education and those who were active in a local self-help group intervene more often.
- Parents who report less satisfaction with the emotional support they received from staff reported intervening more often.

PARENTS OF CHILDREN WITH CANCER

PREDICTORS OF PTSD SYMPTOMATOLOGY

- Treatment Variables:
  - Mother's current perception of life-threat
  - Intensity of treatment (rated by oncologist)
- Environmental Variables:
  - Stressful life-events in last year
  - Low income
  - Low social support
  - Mother employed out of home
- Individual Variables
  - Anxious Temperament
  - Chaotic Family

Posttraumatic stress disorder and family functioning in adolescent cancer

Palcovitz, David; et al Journal of Traumatic Stress. 1998 Apr Vol 11(2) 205-221

EXPERT CONSENSUS GUIDELINES EARLY INTERVENTION

- **Provide information about acute stress reaction and PTSD**
- **Help child/parent understand that it is normal be upset**
- **Encourage conversations among family and friends about the trauma and associated feelings**
- **Educate family and significant others about importance of listening and being tolerant**
- **Help child and family accept the need for repeated retelling**
- **Relieve irrational guilt**
- **Refer to peer support group or trauma counseling if needed**

FAMILY PROTECTIVE FACTORS WHICH ARE OFTEN IMPACTED BY CHILDHOOD CHRONIC ILLNESS

- Time
  - *At a premium during active treatment*
- Family discussions which foster perspective taking regarding those with whom we disagree
  - *Stressed out individuals tend to become (temporarily) egocentric*
- Authoritative disciplinary style (vs authoritarian or overindulgent)
  - *Feelings of powerlessness heighten risk for engaging in coercive parenting strategies*
- Actively involved fathers

Indications for Treatment

- In Harvard study only one-third needed treatment
  - Indications for treatment only if following symptoms persist for several months:
    - Persisting difficulty talking about the ill parent
    - Persisting aggressive behavior not present before the illness particularly if this involves destruction of property
    - Anxiety that does not gradually abate, particularly separation anxiety
    - Enduring somatic complaints like headaches or stomach aches
    - Persisting sleep disturbance such as problem falling asleep, staying asleep or nightmares
    - Persisting change in eating patterns
    - Marked social withdrawal, especially in previously social child
    - Persisting academic reversal
    - Persisting self-blame, guilt, or unworthiness
    - Self-destructive behavior or desire to die regardless of duration

Mediators of Child's Response to Loss

Worden, J. Children & Grief, Guilford

- Increased risk when there is: sudden illness, larger number of young children, concurrent stressors,
- Illness of mother portends more daily life changes and greater likelihood of loss of families emotional caretaker than loss of a father
- Functioning level of surviving parent is most powerful predictor of child's adjustment. Passive coping style predicts greater risk
- Inconsistent discipline and discrepancy between parental and child perception of child's needs predict difficulties

Talking About Loss With Children Guidelines for Parents (Bruce Perry)

- Don't be afraid to talk about death or loss. Children do not benefit from "not thinking about it" or "putting it out of their minds."
- " Share important facts about the event. Share some of your own feelings and thoughts. Sometimes children act as if they have not heard anything you have said, but they have.
- Remember that in the midst of distressing experiences, children are not very capable of processing complex or abstract information. Be prepared to repeat the same information again and again
- Try to understand what the children think about situation Do they place blame on themselves or other?

Making Meaning out of Loss

- In order to assist the child in making meaning, the therapist may ask a series of questions:
  1. 1. If you met another child whose parent was seriously ill like yours, what would you want to tell them about what you have learned?
  - 2. What would you want them to know that might help them?
  - 3. If they thought therapy would be too hard, what would you say to them?
    4. What do you think about yourself now that you've gone through this?

Cohen J. et al. CBT for traumatic grief, Pittsburgh

ALTERATIONS IN AFFECT AND IMPULSE REGULATION

- Chronic and pervasive depressed mood or sense of emptiness or deadness
- Physically self destructive acts
- Overinhibition of anger or excessive expression of anger
- Overinhibition or excessive expression of sexual drive e.g. lack of sexual drive following rape, promiscuity following sexual abuse
- Excessive risk taking associated with persistent feelings of invulnerability

Distressing Reminders
(Layne, Saltzman et a., UCLA)

- Trauma Reminders
  - Outside of me:
    - A place or familiar sight
    - A person
    - A specific time or date
    - A sound or treatment related smell
    - Child has cold
    - A physical scar
    - An activity

Distressing Reminders (continued) ((Layne, Saltzman et al., UCLA)

- Inside of me:
  - An emotion
  - A thought
  - A bodily sensation

Loss Reminders
Layne, Saltzman et al., UCLA)

- Times when we miss life as it was before the illness
  - Shared Family Activities: playing games, going for walks, doing homework together, and eating meals together
  - Changes or Hardship in your Life:
    - Taking on added responsibilities or chores
    - Financial Pressures
    - Losing privacy
    - Changes in friends

QUESTIONS TO ASK ABOUT COPING

- ASK Parent :
  - How well they believe they are coping
  - Who, if anyone, helps them do this
  - What they have found to be most effective and ineffective
  - What they believe would be most helpful in assisting them in dealing with future incidents

Assessment of coping styles

- In light of cyclic nature of treatment separate coping mechanisms may be necessary for different stages of treatment
- Coping style are on a continuum from active information seekers to information avoiders
- Parents with active styles will respond well to getting a maximum of information, rehearsal, and information "Attenders" may cope less well during active treatment and beginning of maintenance than "distractors", however, many attenders become more distressed if discouraged from using coping mechanisms that they find natural
- In early stages the type of coping mechanisms used are less predictive of long term resilience then whether a particular style works for a particular person
- For siblings difference between "parentification" and "required helpfulness"

Monitoring vs. Blunting: Two Modes of Processing Illness Related Information

Miller, SM (1995) Monitoring vs. blunting styles of coping with cancer influence the information patients want and need about their disease. Cancer, 76: 167-177

- Monitoring:
  - Characterized by scanning for and amplifying threatening cancer cues
- Blunting:
  - Distraction from and minimizing of threatening information

Monitoring vs. Blunting: Emotional Reactions

Miller, SM, Fang, CY, Diefenbach, MA, Bales, CB, Tailoring psychosocial interventions to the individual's health information-processing style. In Baum, A. and Andersen, B. (Eds.) Psychosocial Interventions for Cancer, 2001, American Psychological Association Press, Washington, D.C.;343-362

- Studies of women at high risk for breast cancer have shown that high levels of intrusive thoughts increase risk for poor adherence to mammography regimens and breast self examination
- Monitors undergoing follow-up for an abnormal pap smear more likely to be distressed during procedure and to experience pain during 5 days following visit
- Monitors experience more prolonged and severe levels of nausea and depression when undergoing chemotherapy
- Monitors appear to be at increased risk for PTSD like symptoms including repetitive reliving of threatening illness related experiences

Monitoring vs. Blunting: Active vs. Passive Patient Role

Miller, SM, Fang, CY, Diefenbach, MA, Bales, CB, Tailoring psychosocial interventions to the individual's health information-processing style. In Baum, A. and Andersen, B. (Eds.) Psychosocial Interventions for Cancer, 2001, American Psychological Association Press, Washington, D.C.;343-362

- Monitors seek out elaborate information about their illness; blunters prefer minimal detail
- Monitors are typically:
  - Less satisfied with standard amount of information provided in routine medical care
  - More demanding of kindness, reassurance and respect from their physicians
  - More likely to demand increased number of diagnostic tests and prescriptions
  - Less satisfied with treatment team which is, in turn, increased distress and anxiety

Monitoring vs. Blunting: Coping

Miller, SM, Fang, CY, Diefenbach, MA, Bales, CB, Tailoring psychosocial interventions to the individual's health information-processing style. In Baum, A. and Andersen, B. (Eds.) Psychosocial Interventions for Cancer, 2001, American Psychological Association Press, Washington, D.C.;343-362

- Use of positive coping strategies (e.g. acceptance, humor) associated with lower distress
- In general monitors more likely to adhere to routine cancer screening than blunters
  - However, under levels of high stress monitors develop intrusive and avoidant coping strategies that can lead to denial and disengagement from treatment

The Three P's: Predict, Plan, Permission

- Predict to the child that he or she will have times of sadness and grief throughout various points in life. These may be triggered by loss reminders (or trauma reminders).
- Plan for how to optimally cope with these times. This plan may include talking to parent or other significant person, using a specific relaxation technique, visiting a memorial site, looking at bereavement book, or any other activity that will bring the child comfort.
- Permission given to the child to have these feelings at any point in life, and have the child give permission to other family members, to have these feelings and to express these feelings without construing them as a sign of pathology. Parents also need to learn and practice The 3 Ps and to reinforce them in their children.

Coping during exposure to reminders

((Layne, Saltzman et al., UCLA)

- Self-talk
  - Calming self-talk ("I can get through this"); highlighting the difference between then and now ("there are three ways this situation is different from when I was beaten up")
- Breathing techniques
- Distraction through positive activities
  - Activities that are either physically or mentally engaging or especially pleasurable or relaxing. (E.g. Exercise, sports, hobbies, projects, reading)
- Time-out e.g. take a walk to calm down
- Seek support

Disrupting Negative Self-talk

- NOTICE that you are engaging in negative self-talk) cue this is happening may be feelings of anxiety, depression or fear)
- STOP and ask yourself any of the following:
  - "What am I telling myself that makes me feel this way?"
  - "Do I really want to do this to myself?"
  - "Do I really want to stay upset?"
- RELAX OR DISTRACT
  - Switch gears by breathing exercise, sports, or thought stopping technique (internally shouting "stop!", "Get out!", snapping rubber band)
- COUNTER
  - negative self talk by repeating a positive coping statement over and over again. E.g. "I can handle this", "This will pass," and "These are just thoughts – and I can let them gol."; or repeat single word such as "Relax" or "Calm".

Developing a Personal Coping Strategy: Anticipation

- Before the reminder/stressful situation
  - Reduce unnecessary exposure
  - Anticipate (self-talk, planning, recruit support)
  - Relaxation exercise

Developing a Personal Coping Strategy During Stressful Situation

- During the reminder/stressful situation
  - Seek support from friends, family, medical staff
  - Breathing techniques
  - Time-out
  - Distraction through positive activities (sports, exercise, hobbies, reading)
  - Self talk
    - Calming self talk
    - Difference between then and now
    - Thought stopping
    - Disrupting negative self talk

Developing a Personal Coping Strategy: After the Stressful Event

- Seek support
- Self-talk (praising yourself)
- Journal

The Power of the Trauma Naarative

- Naming the monster
- Pennebaker and the power of journal keeping

Alteration in Systems of Meaning

- Loss of previously sustaining beliefs
- Pessimistic view of the future

Focusing on positive changes is the norm

- Survey of college students that found main preoccupation in the 1950's was finding meaning; now it's making money
- Survey of 271 adolescent to young adult cancer survivors found that of 76% who viewed themselves as different, 69% saw these differences as positive
  - Survivors saw themselves as more mature, more likely to "know" the purpose of life treat others well

Cited in: Stuber, ML: Is PTSD a viable model for understanding responses to childhood cancer? (1998) Child and Adolescent Psychiatric Clinics of North America, 7:169-182

Optimism and the Caregiver

- In caregiver's of cancer patients higher optimism is associated with:
  - Lower levels of depression
  - Less impact of care giving on physical health of caregiver

Vicarious Traumatization

Pearlman, L , Mac Ian, P. Vicarious Traumatization:
An Empirical Study of the Effects of Trauma Work on Trauma Therapists
Professional Psychology: Research and Practice1995 Vol. 26, No. 6, 558-565

- *Vicarious traumatization is* the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae. Such engagement includes listening to graphic descriptions of horrific events, bearing witness to people's cruelty to one another, and witnessing and participating in traumatic reenactments
- Those newest to the work experience the most psychological difficulties
- Trauma therapists with a personal trauma history show more negative effects than those without a personal history

Shattered Assumptions and Meaning

- People tend to believe that the world is good place in which people and events are benevolent
- Most also believe that the “goodness” of an individual determines their lot in life
- People tend to view themselves as “good” competent, in control and unlikely to be vulnerable to trauma

Vicarious Traumatization (empirical findings, continued)

- Exposure to children's trauma may be especially difficult (Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview.(In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1—20). New York: Brunner/Mazel.))
- Gender: Women at greater risk
- Intensity of Exposure: A greater number of survivor clients in one's caseload is correlated with:
  - more disruptions in one's beliefs or schemas
  - PTSD symptoms (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—54.)

Trauma Work and Spirituality

- Trauma work affects the therapist most in the spiritual domain: Therapists' basic faith is challenged when faced with their clients' stories of trauma and human cruelty. Conducting therapy with trauma survivors forces therapists to question their own sense of meaning and hope.
- Paradoxically, empirical research finds that practitioners who treat more abuse survivors reported a more existentially and spiritually satisfying life than those with less exposure to trauma clients. Brady, Jg; Guy, J; Poelstra, P.; Brokaw, B Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists Professional Psychology: Research & Practice. 1999 Aug Vol 30(4) 386-393
  - trauma brings issues of meaning to the forefront Conducting psychotherapy with survivors of trauma can force therapists to challenge their own constructs of meaning and traditions of faith.

Antidotes

- Naming the monster: self-awareness
- Rest, relaxation, physical exercise, avocations, vacations
- Peer support :
  - therapists who use social support as a coping mechanism have fewer trauma symptoms. 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

Cognitive Antidotes

- In circumstance that are not amenable to problem solving controlling meaning may be the only response that is in the control of the individual
- Shifting from threat to “challenge”; crisis as danger and opportunity
- Humor as making nothing out of something, art as making something out of nothing
- Reordered priorities; deeper understanding of life
- Power of doing good (camp story)

RESILIENCE

THREE LESSONS ON COPING

- Knowing what is important and what isn’t
  - story of Field Trials and children with cancer
- One person who cares- importance of making time to share
  - STUDIES OF CHILDREN WHO SURVIVED CONCENTRATION CAMPS
  - WAHLER'S STUDIES OF SOCIALLY ISOLATED ABUSIVE MOTHERS
- To name the damage is to conquer it; understanding effects of the illness and accompanying clarity can be a mechanism for seeing self as survivor rather than as helpless, "damaged" victim

REFRAMING

- Chinese word symbol for crisis= danger and opportunity
- PROBLEM FOCUSED COPING
  - ability to problem solve via focus on what one has control over rather than being pulled into feeling loss of control
- although one can not escape abusive past totally unharmed, recasting the narrative of one's life with a focus on ways one survived trauma is associated with resilience
  - CHASIDIC STORY OF KINGS FLAWED JEWEL
  - HOLOCAUST STORY OF POISONED BREAD

PSYCHOEDUCATION

THE PROVISION OF RELEVANT INFORMATION TO

HELP CHILDREN AND PARENTS PLACE THE TRAUMATIC EXPERIENCE IN PERSPECTIVE INCLUDES:

- **The frequency of the occurrence of the traumatic event**
- **Typical responses of children and parents to the specific traumatic event**
- **Strategies to protect children and parents in the future**
- **Information about relevant agencies/resources i.e. courts, housing, law enforcement**

Structured Psychoeducational Intervention

Fawzy, F, Cousins, N (1990) A structured psychiatric intervention for cancer patients, Archives of General Psychiatry, 47:720-725

- Health Education
  - Information about disease, risk factors, prevention
- Stress Management
  - Stress Awareness
    - Identifying sources of stress
    - Identifying personal reactions to stress (physiological, psychological, behavioral)
  - Stress Management
    - Modifying sources of stress through problem solving
    - Changing attitude towards stressor by viewing stressor through “new light”
    - Relaxation training

Structured Psychoeducational Intervention (continued)

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- Coping Skills
  - Five steps of problem solving
    - Relaxing, identifying the problem, brainstorming, selecting and implementing a possible solution, evaluating
  - Coping methods for cancer
    - Active behavioral methods: e.g. exercise, relaxation exercises, frequent collaborative consultations with physicians
    - Active cognitive methods: focus on positive changes
    - Avoidance methods (typically maladaptive) e.g. avoids being with others, hides feelings refuses to think about illness
  - Integrating above techniques into action using pictures as springboard for role-play