

WHAT ARE THE POTENTIAL BENEFITS OF COUNSELING
FOR TRAUMATIZED YOUNG PEOPLE?

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Introduction to the Topic of Dealing with Trauma

The world in which we live is becoming more and more complicated every day. Events that are transpiring are becoming more negative and more violence related. People of all walks of life have to learn how to cope with these instances. Adolescents and children are not immune from the ills of society. If anything, they are even more susceptible to the direct fallout and repercussions that are created. Younger minds have not had as much time and experience to develop the coping skills and strategies that are needed to deal with such occurrences. It is due to this that counseling can have even greater significance in the healing process in the lives of traumatized young people.

There are many types of negative life events that can affect students. Friends can die, family members can be harmed, the student themselves could be threatened, one could have witnessed an attack, or an illness could set in. There are also natural disasters with which to contend and some children grow up in the presence of war. The relationship with one's parents could be unhealthy, drugs could play a prominent role, accidents happen of all kinds, and medical treatments could have negative side effects. Whatever the cause of the trauma, individuals need the skills to deal with these challenges. Students need to feel as though they have the support of others and that there is assistance out there for them. Sometimes the help comes to them in many forms.

This subject matter is most significant in an educational setting. As part of a comprehensive guidance program, schools need to be equipped in dealing with emergencies that arise; both for individuals and the school as a whole. For students to be successful in academics, they need to feel secure and have peace of mind that they are safe and healthy. Functioning levels are lowered when people have to deal with stress

and negative feelings about themselves and life in general. Unfortunately, many tragic events can greatly affect the normal routine of a school system, such as a school shooting, accidents involving multiple students, or the death of a teacher. Even tragedies unrelated to the school itself can interrupt the daily routine, such as the World Trade Center attack.

The material related to this topic directly corresponds to the lesson plans for the section dealing with Self Efficacy and Attributions (3/1). Part of this discussion was related to coping with personal and classroom stress. This paper won't deal so much with tension caused in the classroom, but more with outside occurrences that would affect the performance and normal interactions in the schools. In the course text, the section labeled "The Concept of Stress" begins on page 573 and continues until 580. From there the next section entitled "Coping Strategies and Styles" goes on until page 592. Within these pages, the notions of *stressors*, *major life events*, *traumatic stress*, *optimism*, *self-efficacy*, and *disclosure* are presented.

Some key terms to consider while reading this paper: 1) *catharsis* – (psychoanalysis) a technique used to relieve tension and anxiety by bringing repressed material to consciousness, 2) *cognition* – refers to awareness and thinking as well as to specific mental acts such as perceiving, interpreting, remembering, believing, and anticipating, 3) *co-morbidity* – the presence of two or more disorders of any type in one person, 4) *displacement* – unconscious defense mechanism whereby unacceptable feelings (i.e., anger) toward a specific person are directed toward a more appropriate person or object, 5) *maladaptive* – personal behaviors that are non-conducive to healthy recovery strategies, 6) *posttraumatic stress disorder (PTSD)* – an anxiety disorder characterized by symptoms of re-experiencing, avoidance of trauma-related stimuli, and

hyper-arousal [American Psychological Association, 1994], 7) *provocative* – tending to arouse or excite a response, especially that of anger, 8) *psychotherapy* – treatment of emotional disorders based on the application of psychological knowledge, as opposed to drug therapy or surgical treatment, 9) *suicidal ideation* – to conceive mental images or to think about taking one’s own life, and 10) *trauma* – (psychiatry) emotional shock that creates substantial and lasting damage to the psychological development of the individual. This material was retrieved from the course text, Larsen and Buss (2005) and *Reader’s Digest Illustrated Encyclopedic Dictionary* (1987).

The articles chosen as research material for this paper concentrate on the treatment modalities that have been most recently studied for use with traumatized youths. There was a considerable gap in the studies done/not done during the 1990’s. It appears as though there was a temporary lull in the research interest during this time. However, along with the considerable overall in the field of school guidance over the past ten years, there has also been a renewed interest in specific studies in the area of adolescent trauma. From this research, there is a general consensus that large and small group counseling is going to become more prevalent and play a greater role in the recovery of psychologically injured young people.

There is a need to specify between two major categories of trauma. The first of which is event-related, meaning that a certain occurrence had to take place (i.e, accident, injury, assault, etc). The second type is the result of trying to heal or cure an injury. This would be related to the medical treatment or the group procedure that could make matters worse for the individual. The focus of this paper will be that of the first type. There is still a great need for more research detailing the repercussions of the latter type.

Feeny, N. C., Foa, E. B., Treadwell, K. R., & March, J. (2004). Posttraumatic stress disorder in youth: A critical review of the cognitive and behavioral treatment outcome literature. *Professional Psychology: Research and Practice*, 35(5), 466 – 476.

Over the years, psychologists have been trying to develop treatment procedures for children suffering from PTSD. The research literature had been somewhat limited until recently. An expanding base of clinical studies related to dealing with youth suffering from serious emotional disturbances (SED's) has been published. Feeny, Foa, Treadwell, and March (2004) review four significant studies that were done using group-delivered cognitive-behavioral interventions. The authors make note that 25% of youth report experiencing a high-magnitude traumatic event by the age of 16 (Costello, Erkanli, Fairbank, & Angold, 2002). Hence, the need for effective treatment is significant.

Methodology

In the first study (A) conducted by Goenjiian et al. (1997), the participants were 64 sixth and seventh graders from four schools who exhibited PTSD symptoms 1.5 years after experiencing an earthquake. Treatment consisted of four 30-minute group sessions and an average of two individual sessions conducted over three weeks in a school setting. The intervention included reprocessing the trauma, clarification of cognitive distortions, coping strategies, grief resolution, problem solving, aggression management, and relaxation. The second study (B) carried out by March, Amaya-Jackson, Murray, & Shulte (1998) used a single-case design. Participants were seventeen youth (10-15 years old) who were diagnosed as having PTSD as the result of a single-incident trauma. Treatment consisted of 18 weekly groups sessions conducted in a school setting with one individual session at week 10. Components included psycho-education, exposure to trauma narratives, interpersonal problem solving, self-talk, and relapse prevention.

In the third study (C) conducted by Chemtob, Nakashima, and Hamada (2002), the participants were 248 children in the second through sixth grades who exhibited PTSD symptoms two years after experiencing a hurricane hitting their island. Youth were randomized to either individual or group treatment. Both formats used a four-session, manual-guided treatment consisting of the following disaster-related modules: Safety and Helplessness, Loss, Mobilizing Competence and Issues of Anger, Ending, and Going Forward. The fourth study (D) carried out by Stein et al. (2003) was a randomized control trial comparing immediate and delayed trauma-focused treatment delivered to children with clinically significant PTSD symptoms. Treatment was provided at school by school mental health clinicians over 10 sessions. Components included psycho-education, relaxation training, imaginal and in vivo exposure, combating negative thoughts, and problem solving, which were similar to other group-administered CBT's.

Results

Among all studies aforementioned, the respondents reported significantly decreased PTSD symptoms compared to those who did not receive any treatment. Results were similar for both group and individual interventions and maintenance of gains was strong at post-test follow-up. Reduced psychopathology was comparable in all groups once they had received a comparable treatment, even if it had been delayed.

Implications

Although the outcomes were highly positive in each study for reducing PTSD symptoms, future research must include measures of functioning. Questions need to be answered as to “whether our treatments improve daily life functioning in such critical settings such as home, school, and peer group” (Weisz & Hawley, 1998, p. 213).

Bronfman, E. T., Campis, L. B., & Koocher, G. P. (1998). Helping children to cope: Clinical issues for acutely injured and medically traumatized children. *Professional Psychology: Research and Practice*, 29(6), 574 – 581.

In this article, the authors discuss the differences between event-related trauma and that which is secondary to medical treatment, termed *iatrogenic trauma*. There are many factors that affect the response rates of children after an injury and therefore require consideration in a psychological evaluation. Lewandowski and Baranoski (1994) list several of these as: 1) development stage of child, 2) cause of trauma, 3) reactions of caregivers, 4) pain, anxiety, and sleep deprivation, 5) available situational support, 6) number and type of other recent stressors, 7) acute or chronic nature of injury, 8) injury or death of friends or family members in same event, 9) community or societal response, and 10) pre-existing psychopathology.

Bronfman, Campis, and Koocher (1998) add three other factors for consideration when evaluating a traumatized child. The first of which is the immediacy of rescue or help, as in how long did the child wait before they received assistance or support. The second factor would be the child's degree of consciousness during the traumatic event. If they were aware of the event, they may be subjected to severe pain, confusion, and fear. Their third consideration is that of the child's pre-morbid psychological functioning. Depending on whether or not they possess more adaptive emotional resources will greatly predict the level that they will be able to make sense of their experience as a whole.

Application of the Medical Crisis Counseling Model (MCCM), as developed by Koocher and Pollin (1995), is delineated by the article's authors. Eight central issues or fears commonly experienced by people during medical crisis are described. These are: 1) loss of control, 2) loss of self-image, 3) dependency, 4) stigma, 5) abandonment, 6) fear

of expressing anger, 7) isolation, and 8) fear of death. These concerns are also related to the reactions of the immediate family members as well as the traumatized child.

The treatment phase of the event-related traumatic injury is broken down into several key components. The first of which is to review what has happened so that the youth has a firm understanding. Second comes the sensory processing of the event whereby the child is asked what they saw, heard, smelled, tasted, or felt during the incident. Next is to explore and clarify beliefs related to the trauma so that the child may make sense of what happened to them. Then it may be helpful to employ the use of posttraumatic play and drawings, which are considered to be less threatening. There will be a need to explain any medical interventions carefully and to reassert that the procedures are intended to help the child. And finally, it will be necessary to provide help and support to the parents so that they may manage their own affect.

Implications

The directives that are provided by Bronfman et al. (1998) show how it is possible to increase the likelihood of successful psychological recovery. By taking into consideration many new factors, the positive effect of counseling may be significantly greater. It was shown that there is a counseling model created for these types of traumatic situations (MCCM). What is also learned is that successful treatment is also dependent upon the potential effects of close friends and relatives who may have their own issues to contend with before being able to provide effective support. Knowing which key factors are most likely to affect the counseling process is a major step forward in greatly increasing the likelihood of recovery and positive future outcomes.

Saltzman, W. R., Pynoos, R. S., Layne, C. M., Steinberg, A. M., & Aisenberg, E. (2001). Trauma- and grief-focused intervention for adolescents exposed to community violence: Results of a school-based screening and group treatment protocol. *Group Dynamics: Theory, Research, and Practice*, 5(4), 291 – 303.

New statistics that are coming to light show that juveniles are two times more likely than adults to be victims of serious violent crime and three times more likely to be victims of simple assault (Sickmund, Snyder, & Poe-Yamagata, 1997). This study addressed basic questions related to the identification and treatment of students with histories of community violence exposure and associated distress. Trauma in adolescence has been linked with long-term developmental disturbances, including disrupted moral development, missed developmental opportunities, delayed preparation for professional and family life, and disruptions in close relationships (Layne, Pynoos, & Cardenas, 2001). Group approaches for adolescent counseling are researched.

Methodology

The program described here was adapted from intervention programs developed by members of the University of California, Los Angeles (UCLA) Trauma Psychiatry Service and used in Southern California with adolescents traumatized by community violence. The treatment consists of manualized trauma- and grief-focused group psychotherapy based on five foci which include traumatic experiences, reminders of trauma and loss, the interplay of trauma and grief, post-trauma adversities, and developmental progression (Saltzman, Pynoos, Layne, Steinberg, and Aisenberg, 2001).

The group psychotherapy protocol consists of 20 semi-structured sessions, which are divided into four modules. The participants consisted of 812 students who were surveyed and 26 students who took part in the group psychotherapy program. The breakdown was 61% boys and 39% girls ranging in age from 11 to 14 years of age. The

ethnic composition of the group members was 68% Hispanic, 28% African American, and 4% Caucasian. The measures used were the *Community Violence Exposure Survey*, the *UCLA PTSD Reaction Index – Adolescent Version*, the *Reynolds Adolescent Depression Scale*, the *Grief Screening Scale*, the *UCLA Trauma-Grief Screening Interview*, and the *Grade Point Average (GPA)* of each individual student.

Students who received parental permission completed the surveys in groups of 30. Translation was provided and referrals were accepted for consideration. Based on certain scores, potential students were invited in for interviews. Dependent upon what was learned in the interviews select students were accepted into the program. Five trauma-focused groups were formed and members were assigned based homogeneity levels.

Results

Post-traumatic stress scores decreased significantly pre- to post-treatment. Of greater clinical relevance, the post-treatment mean PTSD score fell below the clinical cutoff point. In the students reporting histories of significant loss, complicated grief symptoms decreased significantly pre- to post-treatment. GPA also improved significantly and there was no attrition among group members over the 20-week period.

Implications

These research findings show that there are great benefits to be derived from group counseling being provided to severely traumatized students. Effective treatment protocol can not only reduce symptoms of stress and grief, but also improve the academic performance within the school setting. This goes to show a direct correlation between a sound emotional state and that of having a higher level of personal functioning. The more negative factors that can be alleviated the better chance of attaining school success.

Weinberg, R. B. (1990). Serving large numbers of adolescent victim-survivors: Group interventions following trauma at school. *Professional Psychology: Research and Practice*, 21(4), 271 -278.

Recent research has documented that violence toward and around young people is on the rise. In 1986, more than 39,000 American adolescents and young adults lost their lives, with more than 75% of these deaths due to accidents, suicides, or homicides (National Center for Health Statistics, 1988). When a youth dies unexpectedly, a logical place to provide services is at the victim's high school because it is likely that many classmates and friends will be agitated by the death. Complicating the problem is the fact that some adolescents in need of help will not seek it because of denial, mistrust, or the stigma of talking with a counselor (Bernstein, 1989).

Weinberg (1990) describes an intervention plan that can be used by high schools faced with a large demand for crisis services after a major trauma. The procedure consists of developing the intervention plan, conducting large assemblies designed to accommodate as many as 200 students at a time, and offering small group counseling for 6-12 students. Although the procedure that is described has not been empirically evaluated, the assembly and small-group protocol have been guided in their development based on experience gained in five interventions over the past three years.

After the key administrators and personnel have devised a plan, the principal needs to make an announcement at the beginning of the next day telling the student body about the scheduled assembly and the counseling services that will be available. The assemblies have four objectives: 1) to describe, normalize, and encourage healthy grief reactions, 2) to identify students who may need more focused attention, and escort them

to individual or group counseling, 3) to encourage healthy coping behaviors and discourage unhealthy ones, and 4) to confront the issue of suicide (Weinberg, 1990).

Once students-in-distress have been identified, they are invited to participate in small group counseling. The format allows for more careful scrutiny of adolescents who are displaying a serious reaction to the tragedy or who, by nature of their close relationship to the victim(s) or exposure to the incident, may be at greater risk for more serious long-term effects. After initial introductions are completed, students are encouraged to express their fear and sadness with one another. Group support has been identified as one of the most therapeutic factors for adolescents in crisis (Ross & Motto, 1984). Members are asked to examine whether or not they feel any personal guilt related to the situation. Group leaders then encourage healthy coping behavior and problem-solving. When it is time to end, the group is reminded that easement is only temporary.

Implications

Students have expressed various amounts of relief at the end of small group counseling sessions. This is a reprieve that was not likely to have been experienced otherwise. When school counselors are able to identify those students most in need of their services, they are at an advantage to correct a problem before it may become much worse. It is important for adolescents to understand that help and support are out there and available to them at any time. School clinicians are trained in specialized interventions that deal with traumatized youth and their emotional and developmental stages. Paramount to all counseling interventions is the strong and clear message that is presented to the student body that suicide is not an acceptable alternative to coping with life's tragedies. Students needing more help are referred to an outside agency.

Turner, A. L. (2000). Group treatment of trauma survivors following a fatal bus accident: Integrating theory and practice. *Group Dynamics: Theory, Research, and Practice*, 4(2), 139 – 149.

There have been two common methods for trying to reduce psychological distress, that of structured crisis debriefing and trauma-focused group treatment. Mitchell (1983) developed the first structured debriefing intervention for work with emergency personnel. However, most of the work done in process debriefings is done in one session and focuses on the group experience rather than the individual. Turner (2000) reviewed the applicable research conducted on group therapy and directly applied what he knew to a single case study involving international students who were in a bus fatal accident.

Methodology

The participants were originally 17 survivors of the tragedy, all college students from the United States. After initial screenings four elected not to be part of the group, leaving 13 students to attend the 90 minute sessions over the next six weeks. These began the fourth day post-accident and continued for the duration of the cruise, for a total of 11 meetings. The focus of the group followed a similar pattern to that described by Layne, Saltzman, and Pynoos (1998) in their four treatment modules: group building/basic coping, constructing the trauma narrative, coping with loss/grief, and refocusing on the present and the future. An important theme developed among the members for the need to piece together the events of the accident, as no single person had a complete or accurate memory of the experience.

After the ship docked, the author / ship psychologist offered assistance with community referrals for when returning home. Some of the students contacted Dr. Turner during the year and he developed a survey to assess student adjustment issues as a

natural follow-up. The measure consisted of 11 short questions to be answered *yes* or *no*. The instrument was mailed to all 13 students, comprised of four men and nine women, 14 months after termination of the group. The questions addressed four general areas: 1) on-board adjustment following the accident, 2) global evaluation of the bus group experience, 3) PTSD-like symptoms, and 4) post-voyage adjustment. Surveys were returned by 11 of the 13 students, with no explanation of what happened to the other two.

Results

It was learned that 100% of the members were glad that they had completed the voyage, but 82% of them expressed that participation in the remaining field trips and in-port activities was a major source of anxiety and fear. 91% reported that they found the group experience to be helpful, especially in reconstructing their perceptions and memories of the trauma. Turner (2000) found an alarmingly high rate of 91% of the students reported having nightmares about the accident and recurring sensations. As an additional note, 37% of the group reported having sought psychological help at home.

Implications

This study directly shows that most students can benefit greatly from participating in some form of counseling, in this case it was group therapy. The moral support and encouragement provided by other members with common experiences cannot be replicated elsewhere. It is the individual perceptions of the members that make each group unique in and of itself. As noted by Neria and Solomon (1999), debriefing alone is not enough to prevent the development of PTSD-like symptoms in a significant number of participants. Counseling needs to address the particular circumstances at the moment and be flexible and adjusted to suit any particular situation and any individual student.

Conclusion of the Research Findings

It has been empirically shown that counseling, whether it be individual or in a group setting, is beneficial to students who have been traumatized. In the critical review article, all four studies that were reviewed had positive results. They suggested that psychologists treating children with PTSD can use cognitive-behavioral interventions and be on solid ground using those approaches. Practicing psychologists need to take into account developmental factors that may impact treatment delivery, such as expressive and receptive language development, cognitive development, and social support (Feeney et al., 2004). And although, overall, clinicians indicated that cognitive-behavioral interventions were among their top treatment choices, pharmacotherapy, non-directive play therapy, and psychodynamic therapy were also considered frontline treatments by many, despite the lack of existing evidence for their efficacy (Cohen et al., 2001).

To date, factors such as co-morbidity, family functioning, and early termination have not been examined to see how they impact treatment outcome. However, Bronfman et. al. (1998) did support the use of a counseling model that was based originally on dealing with children suffering from illness. With some adaptation, Pollin (1995) felt that it could be helpful in eliciting and treating the emotional responses of children and their families in the face of a traumatic injury or major medical illness. Pre-existing psychological conditions that may have been present before the trauma need to be addressed, in addition to the present circumstances of the trauma itself. Bronfman et. al. stressed that parents and supporting individuals need to be assisted so that they do not hurt themselves or the injured party, emotionally and physically speaking. As well, the medical personnel may need support in dealing with the serious condition of the child.

It is worth noting that not all individuals are properly equipped to work in a group format from the beginning after a trauma has occurred. In the study conducted by Saltzman et al. (2001), they recognized that group therapy was not an appropriate treatment modality for all students. As such, a procedure was established for referring students to individual rather than group treatment on the basis of one or more criteria. Some young people are just not comfortable working in groups, while others are referred by their parents to meet with a counselor one-on-one. Interestingly enough, many parents approved having their children initially screened for symptoms, but then did not consent to have them participate in any type of therapy.

In individual clinical interviews, almost half of the students invited to participate in the group psychotherapy program reported that they had never disclosed their traumatic experiences to their parents (Saltzman et. al., 2001). So schools need to contend with the fact that many adolescents choose not to enlist the help of their parents, usually because they are afraid of getting into some type of trouble at home. When parents are asked for consent, most of the time they don't realize a need for counseling.

Much of the research has shown significant limitations that require counselors to make adjustments to therapy procedures. Many times when a traumatic event occurs, no one was able to foresee it happening. Hence, many studies do not have significant pre-test measures on record. As well, there would be serious ethical issues involving with using control groups in dealing with trauma (i.e., no harm can be done to further science). Due to the expense of interviewing, many samples are not randomized and subjective numbers are used to represent supposed baselines. As specified by Turner (2000), researchers need to find a way to differentiate between event-triggered PTSD in already

vulnerable or predisposed individuals from event-caused PTSD in those with no prior history of problems or trauma. The problems with objective or external evaluation of group experiences with survivors and the risks of low response rates from impersonal assessments have been documented before (Flannery, Perry, & Harvey, 1993).

Counselors are in a prime position to recognize the signs of distress and to identify those students who are in need of specialized psychotherapy. As Weinberg (1990) points out, the discussion of grief is intentionally designed to be provocative, so as to evoke tears and an outward expression of emotion. Attention is drawn to the adaptive behaviors of the students. The issue of suicide is confronted by many school personnel. As was noted by Taylor, Collins, Skokan, and Aspinwall (1988), the restoration of hope and optimism is a necessary component in adjusting to stressful events.

By providing effective counseling treatments, school counselors increase the likelihood of academic success. As Saltzman et. al. (2001) discovered, pre-post reduction in PTSD symptoms was significantly correlated with pre-post improvement in GPA. Whereas different interventions will result in varying outcomes, Young, Ford, Ruzek, Friedman, and Gusman (1997) discuss the need for multiple levels of assessment or screening, combined with a more comprehensive approach to interventions ranging from debriefing to extended treatment options. The bus group (Turner, 2000) appears to support the efficacy of combining the two approaches.

As a result, counselor training programs need to specialize in all research-based interventions and procedures that produce positive outcomes. The higher quality the training provided and acquired, the greater the likelihood of successful counseling taking place. The enhanced emotional state and improved academic performance is paramount.

References

- Bronfman, E. T., Campis, L. B., & Koocher, G. P. (1998). Helping children to cope: Clinical issues for acutely injured and medically traumatized children. *Professional Psychology: Research and Practice*, 29(6), 574 – 581.
- Feeny, N. C., Foa, E. B., Treadwell, K. R., & March, J. (2004). Posttraumatic stress disorder in youth: A critical review of the cognitive and behavioral treatment outcome literature. *Professional Psychology: Research and Practice*, 35(5), 466 – 476.
- Larsen, R. J. & Buss, D. M. (2005). *Personality Psychology: Domains of Knowledge About Human Nature* (2nd ed.). Boston: McGraw-Hill.
- The Reader's Digest Association (1987). *Reader's Digest Illustrated Encyclopedic Dictionary*. Pleasantville, New York: Houghton Mifflin Company.
- Saltzman, W. R., Pynoos, R. S., Layne, C. M., Steinberg, A. M., & Aisenberg, E. (2001). Trauma- and grief-focused intervention for adolescents exposed to community violence: Results of a school-based screening and group treatment protocol. *Group Dynamics: Theory, Research, and Practice*, 5(4), 291 – 303.
- Turner, A. L. (2000). Group treatment of trauma survivors following a fatal bus accident: Integrating theory and practice. *Group Dynamics: Theory, Research, and Practice*, 4(2), 139 – 149.
- Weinberg, R. B. (1990). Serving large numbers of adolescent victim-survivors: Group interventions following trauma at school. *Professional Psychology: Research and Practice*, 21(4), 271 -278.