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**An examination of post traumatic stress disorder in urban
African American children**

Kooperkamp, Elizabeth Blanche, Ph.D.

City University of New York, 1992

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AN EXAMINATION OF POST TRAUMATIC STRESS DISORDER
IN URBAN AFRICAN AMERICAN CHILDREN

by

ELIZABETH BLANCHE KOOPERKAMP

A dissertation submitted to the Graduate
Faculty in Psychology in partial fulfill-
ment of the requirements for the degree
of Doctor of Philosophy, The City Univer-
sity of New York.

1992

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree in Doctor of Philosophy.

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ABSTRACT

AN EXAMINATION OF POST TRAUMATIC STRESS DISORDER
IN URBAN AFRICAN AMERICAN CHILDREN

by

Elizabeth Blanche Kooperkamp

Advisor: Professor Steve Tuber

This thesis is based on field work where the professional participants had little fore-knowledge of post traumatic stress disorder (ptsd). I investigated questions about diagnosing ptsd in a school situation and the course of the disorder within a small group. This particular case studied a group of fourth graders who witnessed the death of a classmate as she crossed the street and was struck by a car. The study employed a questionnaire, class work and small group work. This thesis explored ptsd in children, examined children's struggles with the painful issues of death, vulnerability, and trust brought up by a trauma.

I hypothesized that it was possible to verify the existence of ptsd in children using a self reporting questionnaire. There was enough internal validity within the questionnaire to affirm that it tested for ptsd. I hypothesized that ptsd in children is responsive to group therapy. The specific movement for these children involved a lessening of post traumatic symptomatology and return to age appropriate death concepts (universality and finality).

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I acknowledge the strength of the children in this study and Sandy Barbo, my co-leader, without whom none of this work would have been possible.

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Chapter One

Introduction

Post traumatic stress disorder is entering the mainstream of American media. The American soldiers returning from the war in Vietnam began this movement as their struggles with depression, nightmares and substance abuse finally were linked to their war time experiences (Figley, 1978). The link between their readjustment problems and their war time experiences gained psychiatric credence and had become too widespread to be individualized. By the mid 1980's this shift appeared in the area of children's diagnosis and treatment. The coverage of school disasters (walls falling on lunch rooms, sniper attacks in school yards, bus crashes, etc.) began to include discussions of the surviving children's well being. The media routinely interviews psychologists and school guidance counselors about children's reactions and behavior (Shuchman, 1991).

The outbreak of Desert Shield/Storm illustrates the country's acceptance of post traumatic stress disorder. Schools set up special groups for children whose parents were shipped off to Saudi Arabia. The Army initiated programs for soldiers worried about combat. Mr. Rogers appeared on public television telling parents to talk to their children about the war and maintain routines in the

time of stress. The TV nightly newscasters were self-conscious about the war coverage and its effect on young children. As the war wound down the emphasis switched to de-briefing and readjust-ment stress for the families and soldiers.

Scholarly journals also are publishing an ever increasing number of articles about post traumatic stress disorder and editions dedicated to stress disorder. In 1989 a new journal entitled The Journal of Traumatic Stress appeared.

In the midst of all this new interest there is little coordi-nation. The changes in the field are very rapid. Much of the present research in the area emerges out of a specific disaster where health professionals (with no previous experience in this area) suddenly find themselves faced with upset children. The very nature of trauma; its suddenness and unexpected quality, produces an amateur quality to much of this early work. However there is also a freshness and originality to the approaches various people try as they grapple with the difficulties of treating traumatized children.

It is important to begin documenting childhood instances of post traumatic stress disorder and investigate how they were addressed. Only when more information about the many different circumstances of post traumatic stress disorder can it be possible to develop general theories.

Knowledge about class, race, sex and socio-economic groupings are still unknown in this field. There are unexplored characterological issues about pre-disposition to severe responses and the effect of previous trauma upon a new trauma.

This thesis is based on field work where the professional participants had little fore-knowledge of post traumatic stress disorder. Here I investigate questions about diagnosing post traumatic stress disorder in a school situation and the course of the disorder within a group. This particular case studies a group of fourth graders who witnessed the death of a classmate as she crossed the street and was struck by a car. The study employed a questionnaire, class work and small group work. This thesis examines post traumatic stress disorder in children, explores children's struggle with the painful issues of death, vulnerability, and trust brought up by a trauma. As one nine year old member of the group commented, "This is serious, a life and death matter."

This thesis will investigate seven children's experience in a short term crisis group. The children had witnessed a gruesome accident of another child and were diagnosed with Post Traumatic Stress Disorder. I am interested in the development of the group and the working through of the specific trauma: their reaction to the violent death of a classmate. Therefore, it is necessary to

examine the nature of post traumatic stress disorder and the nature of groups. The literature review is divided into four sections; 1) post traumatic stress disorder definitions; 2) work with post traumatic stress disorder victims; 3) theories about group development, both adult and child; 4) children's comprehension of death; specifically non-familial death.

Post Traumatic Stress Disorder Definitions

Historically, post traumatic stress disorder is linked to Freud's writings on trauma: on the repressed viewing of the primal scene, on war neurosis, on breaking of the stimulus barrier, and on the repetition compulsion associated with anxiety primarily in Beyond the Pleasure Principle (1915). Freud (1914, 1917) used trauma to denote two different types of experiences, though in both cases he held that the psychic trauma breaks the protective shield around the ego and caused both a repression of the event and a compulsion to repeat as a form of mastery. The problem for Freud lay in the area of actual experience. The trauma could develop from a real occurrence like war where the experience overwhelms the ego. An early fantasied sexual excitation or early witnessing of primal scene material could also develop into a trauma when triggered by a later experience. This view incorporates the notion that the trauma occurs because of an inability to organize new information or events with past repressed memories.

Anna Freud (1969) maintained the metaphor of a stimulus barrier in her own writing. She viewed trauma as an external disturbance of the person's organization of relations (the ego functions). Anna Freud left open questions about predisposition to experiencing trauma and the possibility of an external trauma being heightened by matching an internal wish. She ended "On Psychic Trauma" by suggesting trauma could be seen as "shattering, devastating, causing internal disruption by putting ego functions and ego mediation out of action." (1969 p. 242).

"Self psychologists" (Ulman and Brother, 1988) emphasize that trauma occurs after a real event shatters central organizing fantasies of the person. In Kohut's writing (1977, 1984) the emphasis is on the traumatic shattering of the self. The trauma produces the dissociative symptoms common in post traumatic stress disorder as the person attempts to cope with the destruction of the old fantasies and simultaneously creates new central organizing fantasies. This model thus includes the curative attempt at self-restitution which (without treatment) remains dissociated and faulty. When trauma is understood within the model of self psychology, (Feldmann, 1988) it is the force that "can disrupt a previously intact self structure... and shatter narcissistic fantasies"(p.282). The trauma destroys the normal sense of grandiose invulnerability from death and leaves the victims fragmented

with feelings of intense disintegration anxiety. The trauma is also described (Benyakar, Katz, Dasberg & Stern, 1989) as an experience which cannot be integrated into the former structures of self and meaning. The treatment then requires a creation of a therapeutic state which provides stability of space and time where the traumatized person can rework relationships and reestablish autonomy.

Adult Symptoms of Post Traumatic Stress Disorder

Post traumatic stress disorder became a classified syndrome in the 1980's, though the methods of defining the diagnosis changed somewhat between the DSM III and III-R (1980, 1987). It is now defined as exposure to an event outside of the normal range of human experience. The disorder occurs after traumas initiated by witnessing sudden death or violent attacks. Here a person's understanding of safety and predictability is destroyed. Robert Lifton (1982, 1988) investigated survivors of natural disasters, the Holocaust, and the Vietnam War. He wrote about the experience of trauma as "an assault on and threat to the entire self" (Lifton, 1988, p.30). He stressed that the trauma derives its power from its connection to death and the consequent symptoms of this close encounter with death. Lifton is most concerned with the problems of 'survival guilt' the person being "haunted by images that can neither be enacted nor cast away" (Lifton, 1988, p.21) and psychic numbing, the suspension of feeling and symbolizing. For

Lifton the trauma disintegrates the old ways of living and understanding the self in relationship to the world. Coping mechanisms (frequently created to prevent total annihilation) do not allow a reintegration and creation of new relationships.

Horowitz (1979,1980) approached the issue of post traumatic stress disorder from a cognitive information processing model, but ended up with a similar explanation of world views. He cites the intrusive ideation and the episodes of numbing as the most frequent signs of post traumatic stress disorder. Horowitz, like Lifton, sees the power of the trauma as its ability to affect homeostasis. The particular stress-inducing life event is one which human action cannot alter so inner models or schemas must be revised. (1979, p. 244). The stress makes the previous models "discrepant with new realities". The symptom of intrusive ideation is painful precisely because it brings up the discrepancy. "Each representation leads to the reactive ideation that reflects the discrepancy between the recent event and inner models of how it was, or was fantasized to be, in the past" (1980, p. 91).

Janoff-Bulman (1985) argues that trauma affects the victim by "shattering the very basic assumptions that victims have held about the operation of the world" (p. 16). The traumatic event cannot be assimilated as it produces psychological upheaval especially in three areas; 1) belief

in personal vulnerability; 2) perception of the world as meaningful, comprehensible, controllable and just; and 3) the self as no longer regarded positively but felt as powerless, helpless and deviant (p.18). The severity of this disorder is that it attacks the core of the system we use to understand our self and relationships in the world. To use Erikson's (1963) model, it opens up again the central issue of trust versus mistrust, so that the victim must rebuild, reintegrate or revise inner models to reflect the experience of the traumatic event.

By the late 1970's the psychiatric community recognized the trauma disorder and its relationship to witnessing grotesque death or undergoing a life threatening experience (Green, Gare, Lindy, Gleser & Leonard, 1990; Pitman, Altman & Mancklen, 1989). The Vietnam War can be credited with changing the focus of the trauma discussion from infantile trauma or ego vulnerabilities to specific external trauma and a specific set of responses. As veterans came home and began entering mental hospitals in increasing numbers, the psychiatric community was forced to address the stress disorder as a separate diagnosis (Figley, 1978). Issues of predisposition and history of previous mental problems were dismissed as the extreme events were found to overwhelm and minimize any past problems (Green et al., 1990; Hocking, 1970). The most frequently cited symptoms of post traumatic stress disorder in veterans were numbing of emotions and the

uncontrollable reexperiencing of the trauma occurring in dreams or as intrusive thoughts (Janoff-Bulman, 1985).

Once post traumatic stress disorder became an established or real entity the mental health profession began using it to explain human responses in other disasters besides war. The trauma work made a natural link with crisis literature. The first application was in natural disasters. The flood at Buffalo Creek, where there was both large scale property loss and human death, is an example of a natural disaster leading to post traumatic stress disorder in the victimized population. As in the Vietnam studies, those who witnessed more death and destruction or came closest to losing their own lives were most at risk (Frederick, 1985; Lifton & Olson, 1976; Newman, 1976).

There is some evidence that 'acts of God' cause fewer post traumatic stress disorder victims amongst a given population than those where a person is the causal factor. A 'natural' disaster is technically called an 'act of God' and is distinguished from those caused directly by people. The theory holds that the extra weight of a person deliberately violating accepted standards of justice increases the likelihood of post traumatic stress disorder (Gilliband & James, 1988). In his work with children who witnessed parental murder, Malmquist (1986) also found that the post traumatic disorder was "more severe and longer lasting when the stressor is of human design rather than

seen as a misfortune in nature" (p.322).

There are three categories amongst the human caused groupings; the engineering accident variety (e.g.Three Mile Island, the New York state thruway bridge collapse); an individual inflicting physical harm on another (e.g. sexual abuse, rape, torture); and random group violence (e.g. sniper attacks, group kidnapping). Post traumatic stress disorder has been cited by the mental health community to explain the type of reaction people have to these three categories of disasters (Blom, 1986; Burke, 1982; Collins, Baum & Singer, 1983; Dillard, 1988; Fischman & Ross, 1990; Terr,1981).

Childhood Symptoms of Post Traumatic Stress Disorder

When post traumatic stress disorder became a more generalized concept, no longer reserved for the effects of war, children became seen a part of the at risk population. In both the natural and human disasters, children's responses to the trauma were recognized as fitting the diagnosis of post traumatic stress disorder. An earthquake in Italy in 1980 killing 4000 people traumatized the surviving villagers. In an epidemiological study Gallante and Foa document the prevalence of psychic trauma in children (Gallante & Foa, 1986).

There are some differences linked to the child's developmental level. Most fundamentally, a child's degree of post traumatic stress disorder is tied to the parental

response. Parents who acknowledge the trauma and the child's needs to resolve it have less traumatized children (Anthony, 1986; Blom, 1986; Burke, 1982; Gallante & Foa, 1986; McFarlane, 1984; Newman, 1976).

This issue of dependence upon adults includes the paradoxical problem that post traumatic stress disorder destroys a child's sense of trust. As they were not safe from the trauma, the very adults they depend upon were also the ones who betrayed them by allowing the trauma to occur (Hyman, Zelikoff, & Clarke, 1988). In Lyons' (1987) review of post traumatic stress disorder on children leads to her conclusion that "children appear to be especially vulnerable to a collapse of both basic trust and autonomy" (p. 350).

Beyond the above mentioned dependency issue, children's different symptoms can be explained by understanding three areas of the child's world which separate them from adults; 1) they go to school and are in the process of continually learning new information; 2) play and active daydreaming are their primary means of symbolizing the world; and 3) their defence systems are less developed. Children thus report problems in these three areas: concentration difficulties, repetitive traumatic play or day dreams, and regression. Though this particular system is not used by the variety of writers who discuss children and post traumatic stress disorder, it serves to organize what they report.

It is also helpful to keep in mind the theoretical

model of why the symptoms appear. Why does the trauma undo all of the child's intrapsychic work of organizing and relating to the world? Lenore Terr (1983a) defines the traumatic experience as a sudden, unanticipated and intense event; the ordinary coping mechanisms and defenses are insufficient to prevent the child from being overwhelmed with anxiety. Developing an internal organization forms the basic task of childhood. Werner and Kaplan (1967) emphasize the importance of children developing out of continually shifting relationships. A child, beginning with the primordial sharing situation, is continually involved in social relations that form the basis of new relations with objects in the world. At each point the child both builds on the old understandings and discovers radically new ways to see the world. If the basic task of development is thrown into question by a disturbance too great to fit into previous relationships the child has developed, the child becomes traumatized.

To give an overview of the different approaches to symptom classification, I will examine examples from the classic writings on childhood post traumatic stress disorder. Lenore Terr (1979; 1983) lists seven differences between children and adults. She is particularly interested in how children neither blackout the incident nor suffer from true flashbacks. They do, however, develop foreshortening of the future. Terr finds children

frequently exhibit partial behavioral reenactment of the trauma and repetitively play the trauma. The children gain little relief from these repetitions as they maintain a high anxiety level around the unresolved trauma.

Eth and Pynoos (1985; Pynoos & Eth; 1986) discuss school age children's response to trauma as creating school problems. They believe the children use obsessional defenses and isolation of affect to control the trauma, repeatedly reciting every detail of the trauma. Eth and Pynoos emphasize the behavioral changes in children, the fears about enjoying themselves, relating to friends and family, an awareness of feelings and the child's propensity to reenact segments of the trauma in play and daily life. Frederick (1985) agrees with these theorists on the short term symptoms. Frederick adds long term symptoms: namely, an increase in delinquency, unusual fantasies and vulnerability to future stress. Frederick also discusses how children feel an altered sense of power over the self caused by the trauma breaking the childhood belief in omnipotence regarding harm and a too early awareness of fragmentation and death. Newman (1976), in her work at Buffalo Creek, found the children showed a modified sense of reality. They ascribed power over events incorrectly and this increased their vulnerability to future stress. Like Frederick, she discusses an heightened awareness of death.

The classic writers on childhood post traumatic stress

disorder stress different aspects of the disorder and studied the children under varied circumstances. Terr is concerned with distinguishing childhood post traumatic stress disorder from adults and consequently concentrates on these differences. Eth and Pynoos (1985; Pynoos, Frederick, Nader, Arroyo, Steinberg, Eth, Nunoos & Fairbanks, 1987) are the most interested in the interactions between the child's school life and post traumatic stress disorder. They examine the difficulties caused by depression, concentration lapses, a generalized style of forgetting and intrusive thoughts all of which impact upon a child's abilities to continue learning. Newman's (1976) earlier work is not couched in the behavioral symptom language now used in DSM III-R. However, her three categories about reality vulnerabilities and awareness of death are another way of classifying the behavior that shift in traumatized children.

Lahad and Ayalon's (1991) work on children traumatized during war situations identifies various symptoms already mentioned. Interestingly, they include the disruption of one's identity and suspicion towards and alienation from society as trauma symptoms. They emphasize the issue of exposure or proximity to the event, and they note the significance of the victim being of the same sex, age or social status of the witnessing children. The more exposure the greater likelihood of trauma. Knowing the person and being in dangerous areas where the chances of repeated

exposure also intensifies the stress.

In a review of the DSM III-R definition of childhood post traumatic stress disorder, Brett, Spitzer and Williams (1988) compile many of these disparate theories. They develop a list of five symptoms from the literature: 1) reexperiencing the episodes through repetitive play containing themes or aspects of the trauma; 2) the loss of recently acquired developmental skills or regression to an earlier maturational level or a manifestation of withdrawal and diminished interest in significant activities; 3) a sense of foreshortened future and/or an inability to achieve expected life goals in a career and family; 4) the development of omens that are thought to predict future untoward events; 5) psychological symptoms such as generalized fearfulness, separation anxiety, and personality changes" (p.1233-4).

Trauma Therapy

Much of the writing about post traumatic stress disorder documents its existence, its symptoms and symptom duration. (Pitman, Altman & Macklin, 1984; Smith, North, McCool & Shea, 1990). However, for my particular work the more relevant issue concerns the therapeutic response to the syndrome. Whatever particular form the therapy takes, there is general agreement that the sooner therapy follows upon the trauma the better. The therapy stresses normalizing the trauma and returning the person to a pre-trauma level of

functioning (Ochberg, 1991; Schwarz & Prout, 1991) The therapeutic techniques discussed in the literature generally fall into three arenas; individual therapy (analytic or behavioral); large group or community work; and small group work.

The individual therapeutic work is typically described as 'working through' the trauma with little description provided as to how or at what point one has worked through the stress. For example, Horowitz (1979) writes "working through the meaning of the stressful event is part of a general completion tendency aimed at keeping inner models as congruent with reality as possible" (p. 262). Horowitz (1980) actually sees the symptoms of intrusive thoughts as potentially therapeutic because it can serve as a gradual self dosing (similar to a flooding technique) and thus allow the individual time to reorganize the inner models. Figley (1985) also emphasized the survivor of post traumatic stress disorder needing to integrate the catastrophe into one's life before the trauma. He sees this as a process beginning with the catastrophe. When the person feels safe again there is a period of relief and confusion followed by avoidance to relieve the anxiety caused by the trauma. The person then needs to move into a period of reconsideration where the trauma can be confronted and finally achieve a state of adjustment to the trauma and one's past life before the trauma.

For a school system, large group work is most frequently done in a single consultation. After a trauma (often sudden death of a teacher or pupil or a natural death) professionals come in to a school and meet with pupils, teachers and classrooms. This work is usually educational: informing people what happened and what responses they are likely to have or see in others (Zinner, 1985). Bauer (1976) describes this as a basic intervention strategy where one counteracts denial, frees affect, provides support for the early mourning period and monitors the system for on going mourning. This large group format is often used in school after a student suicide. Klingman (1989) describes a three day intervention where the counselors met with students in their classrooms to provide the basic information, met with the teachers to help them cope with students' responses, administered questionnaires to determine who was most at risk, interviewed high risk individuals and held a parent meeting. In this form the work is mainly done by the teachers with guidance from a mental health team. The nature of the work is predominantly factual both about the traumatic event and about the students' reactions. A variation on this approach is the short term work with an entire class using large group discussion, show and tell, and picture drawing as reported in the case of a third grade teacher's sudden death (Brooks, Silverman & Hass, 1985). In one study originally designed

to be a class oriented response to a traumatic suicide, a group of children appeared so clearly symptomatic the focus shifted to a short term twelve week crisis group (Alexander & Harman, 1988).

The above group of children unknowingly called upon a history of group theory when they expressed the need for a group. In the literature these groups are distinguished from group psychotherapy because their goal is to return the person to the pre-trauma level of functioning, recover coping skills and support systems and focus on the present and future (Aguilera & Messick, 1982). The fact that the groups are made up of people who have all suffered from the same or similar trauma is in itself helpful. The membership counteracts the feeling of deviance victims often feel.

The group process helps to reestablish the pre-trauma sense of relative invulnerability by becoming a supportive caring environment thus challenging the newly formed internal perception of the world as malevolent and threatening (Janoff-Bulman, 1985, p. 28). The group work seems to break down some of the overwhelming aspects of post traumatic stress disorder that one is alone and suffering in a unique and irreparable manner. This experience of discussing feelings and experiences facilitate the active problem solving and reintegrating needed to repair the damage of the trauma (Silver & Wortman, 1980). Figley (1985) discusses the gradual process of healing within the group

which allows for the "recapitulating and reconstructing of traumatic facets of the catastrophe. A new world emerges which incorporates catastrophe traumata and their wake" (p. 404).

Adult Trauma Therapy

As with the diagnosis itself the Vietnam veterans problems encouraged the psychiatric community to develop new therapeutic responses. There are three primary modalities used with Vietnam veterans: psychodynamic (usually group), behavioral (usually individual emphasizing flooding and desensitization) and psychiatric (usually drugs with some individual monitoring). These are traditionally seen as very disparate therapeutic models. However, in the case of post traumatic stress disorder, the symptoms force therapists to examine the same question: how to facilitate the integration of the posttraumatic event into the person's present day life? (Denton, 1989; Fairbanks & Nicholson, 1987).

As the hopes for a 'cure by time' diminished, veterans themselves began voicing a desire for group treatment and some became therapists running groups for veterans (Blank, 1982; Egendorf, 1975). Walker and Nash (1981) and Scurfield (1985) report their success in treating Vietnam veterans suffering from post traumatic stress disorder in the group modality. These authors cite similar reasons for this choice of treatment modality. Walker and Nash (1981) found

the group reduced feelings of isolation, guilt and stigma that each member was the only one who had experienced the war as traumatic. The authors structured the groups to emphasize member confrontation and support rather than therapists offering personal insight interpretations to help rebuild the veterans sense of trust and control. As the members worked together the sense of group or community developed allowing a processing of the rage and unfinished issues. Scurfield (1985), after much work with Vietnam veterans, claims simply that "group treatment is the treatment of choice" for post traumatic stress disorder. He cites five reasons for this: 1) reduction of isolation thereby providing a sense of community; 2) reduction of feelings of stigma and restoration of self pride; 3) confrontation by peers more acceptable and reality oriented because of similar experience; 4) opportunity to process unfinished business from the trauma and post trauma; and 5) help to express emotions freely (p.230-231).

The Israeli army has done much work with war trauma (Goren, Triest, & Margalit, 1986). They instituted a program of short term trauma groups for the soldiers held in hospitals or camps right beyond the battlefield with a rapid return to the front. Group therapy is the treatment choice because they see a value in the projective identification which allows for destruction of the victim's feelings of isolation and uniqueness. The group promotes cohesiveness

by containing the emotions and fears of the members.

This modality was also found to be effective with other types of trauma. Fogelman and Savian (1979; 1980) used short term group therapy with adult children of Holocaust survivors and reported success for similar reasons in that it reduced the sense of isolation by allowing the sharing of feelings and concerns with people of similar traumatized backgrounds. Extending the definition of trauma to include the fear of death and loss of body integrity as Lifton suggests, various hospitals now have group therapy for patients who have had life threatening illnesses (D'Afflitti & Weitz, 1977). Group therapy has also been used for survivors of torture. Fischman and Ross (1990) conducted eight week groups focussing on the symptoms and the reality of the torture. The groups allowed members to attain gradual psychological reorganization.

Childhood Trauma Therapy

Though there are many theoretical questions about children working in groups; groups are and have been a treatment of choice for children in crisis. The theoretical issues will be dealt with in the chapter on group development and process, here I will concentrate on various rationales and examples of group work for traumatized children. Most generally, time limited crisis groups for children are recommended because they: 1) help children accept the reality of the trauma; 2) mobilize existing

coping mechanisms; and 3) help discover and build new coping mechanisms without giving false reassurance (Sandoval, 1985). Similar to the adult models, the trauma disrupts the child's world and the group becomes the vehicle to recreate the inner world necessary for future healthy functioning. Short term child groups have the ability to deal with here and now events while providing a corrective emotional experience. This, in the view of Scheidlinger (1984), makes group work the treatment of choice for reactive disorders like an isolated trauma.

Terr (1983) sees therapy for traumatized children having the three fold purpose of: 1) teaching children alternative solutions; 2) relieving the guilt and fear; and 3) reducing the sense of foreshortened future. She argues (1990) that group work can be very helpful to children especially if the trauma was school connected and the children have a similar trauma experience. Frederick (1985) expands on the idea that children need to talk and work out alternatives. He believes groups are valuable precisely because children can interact with each other. The process of interacting leads to the creation of a supportive environment where children learn their fears and experiences are to be expected and not unique (1985, p. 92).

There are five types of trauma most frequently cited in the literature where group work is discussed; 1) natural disasters; 2) death of a teacher or pupil; 3) shooting or

terrorism; 4) sexual abuse; and 5) divorce (this is not to say all children whose parents divorce suffer trauma but that in particular instances the divorce may totally disrupt the child's world resulting in post traumatic stress). It is important to remember that children are in a double bind (even more so than adults) in regard to post traumatic stress and treatment. The trauma represents a breaking of their trust in adults and the world to keep them safe and yet they have to depend on adults to give them the treatment to restore their lost sense of order and trust.

The loss of basic trust is compounded by the adults' feelings of failure. The failure stems from the adult's feelings of not safeguarding the children from the trauma in the first place. The adults (parents, teachers, and mental health professionals) wish they could have protected the children more and have difficulty tolerating their own feelings when children describe their pain (Eth & Pynoos, 1985, p. 88). This dilemma colors the treatment offered to children in two ways. Some writers discuss how they were thwarted by schools and or parents from offering treatment because adults felt the children were better off 'forgetting' the trauma (Blom, 1986).

The second effect is more subtle. It emerges in the structure and nature of the group treatment design. Rather than following either the adult model of trauma groups where the participants come in and work or the child group therapy

model where children play and talk out their issues, children's trauma groups tend to be organized. This seems to happen out of the desire to repress the trauma; it is painful for adults to hear children's anguish. If each meeting is tightly run with the adult's agenda, there are less opportunities to express emotions (Rosenthal, 1978).

There are virtually no control group outcome studies about the therapeutic value of these groups. Nor are there verbatim reports as to what the children said in the groups. Instead, there are descriptions of the group agenda. Examples from the different types of traumas will illustrate the methods in organizing children's crisis groups.

The Italian earthquake treatment plan developed by Gallante and Foa (1986) clearly illustrates the dilemma of adults organizing an activity while children use it to achieve their own needs. In a seven session treatment plan groups of four children met once a month in some of the villages most severely destroyed by the earthquake. In each session the children drew pictures and were read a story on a specific theme or were organized into a role playing drama on a delineated topic; i.e. "role playing being parents, teaching children to survive in various emergency situations, i.e., floods, earthquakes, and accidents" (1986, p.360). The therapists list the objectives and activity for each session. They then briefly describe what happened in each session. The children responded to the

agenda by retelling their own earthquake stories, produced predictions about the end of the world, and some denied any feelings about the devastation no matter what the stated agenda was. Gallante and Foa found that by the fourth session the repetition of earthquake stories peaked along with fear of recurrence and other fears. This study included a comparison to children in villages where there was no treatment available and found a significant reduction in at-risk scores for children in treatment. The authors note that the two other villages where the at risk scores dropped organized their own group treatment programs where children could "express their feelings" (1986, p. 363).

When there is a death in a school, particularly a suicide by a fellow student the school response tends to center on facts and death education. The emphasis is placed on establishing the veracity of what happened, and on the finality of death. The groups are usually entire classrooms where discussions are held by counselors or teachers in collaboration with a counselor for a few days following the death. (Zinner, 1987). As with the Galante and Foa work the children involved use any opportunity to handle the trauma by discussing the event, all similar traumas and their fears about the future. Bauer (1976), who recommends small group discussions and school education goes on to describe how the children "bring an amazing array of thematic problems. Although triggered by the shared event, these deal with

personal elaborations. Yet, the manifestations of such highly meaningful stresses allow them to be examined and often worked through fairly easily and lead to a subsequent increase in coping and mental health" (1976, p. 54). This is similar to the work of Alexander and Harman (1988) who went into a school after a thirteen year old killed himself, with the intention of leading a didactic session with each class. After six children expressed a need to talk and reported previous suicidal thoughts, Alexander led a twelve week group where they discussed their fears about suicide, poor self concept, excessive self doubts, fear of loss, grief over previous losses, self blame and self recrimination (Alexander, personal communication 1990).

The terrorist attack in an Israeli town in April 1979 traumatized many of the children in the apartment building and surrounding neighborhood who witnessed the shooting and killing. A crisis team went into the schools immediately, first working with the teachers to prepare them for the children's reactions and then setting up small groups run by the remedial teacher for the children at highest risk for post traumatic stress disorder. The article does not describe the content of the four week sessions. They reported a process of high anxiety and fears followed by aggression anger and desires for revenge which in turn was replaced by more objective analysis of the situation. The group leaders emphasized active coping skills and worked on

anticipatory guidance "because the children brought up repeatedly, and some even compulsively, the possibility of another occurrence of a terrorist attack in the very near future" (Klingman & Ben Eli, 1981, p. 530). The groups were also given desensitization training to noise and fears of the beach (where the killings took place).

The inclusion of sexual abuse and divorce among trauma groups is based on the notion that children referred for these groups have been identified as not adjusting to an event that shattered their sense of the world (Patten, Gatz, Jones & Thomas, 1989). The groups themselves are similar in that they are homogenous in type of trauma and short term. The obvious difference that they did not all suffer at the same event is overshadowed by the generic quality of their symptoms and experiences. Finkelhor and Browne (1985) believe the most important similarity is the psychic change the sex abuse trauma causes by breaking the trust of a child. These children show feelings of powerlessness, low self esteem, aversion to intimacy and lack of faith or trust in others.

In their work with preadolescent girls who were sexual abuse victims, Kitchur and Bell (1989) report the following four issues predominate in all the girls: 1) low self esteem, isolation and alienation; 2) impaired ability to trust; 3) distorted learning, misallocated guilt and role confusion; and 4) impaired abilities of self mastery and

control. They led sixteen weekly sessions which followed a set agenda of snack, a check on each girl's feelings, a film or guest speaker on particular themes and individual journal writing (which were then read by the therapists to determine progress, an interesting technique when trust is such an overwhelming issue). Kitchur and Bell found the groups were valuable in breaking down the sense of uniqueness, providing an arena for developing social skills and relationships and addressing the misperceptions the girls had about their experiences. Pescosolido and Petrella (1986) worked with groups of four and five year old sexual abuse victims. They had hourly group sessions composed of arts and crafts, snack and discussion. The discussion were on specific issues with a three-fold purpose: educational, psychotherapeutic and preventative. The themes, chosen by the therapists, included: anger, touch, perception of males, trust, guilt, separation/abandonment fears, low self esteem, maternal identification, body imagery problems and self destructive ideation. They report a lessening in the girls' psychological isolation and empathic bonding emerged out of the commonality of experience and sharing of painful affect.

The divorce groups are the most frequently cited in the literature. They emerged as an organized entity in the late 1970's largely through the work of Cantor (1977) who developed a series of sessions based on drawings, books, films and psychodrama. These groups stress the sharing of

common experiences, clarifying feelings about the divorce, gaining emotional support and learning new coping skills for the new family dynamics (Drake & Shellenberger, 1981; Goldman & King, 1985; Wilkinson & Bleck, 1977). The specifics of the eight sessions changed as new books or techniques were added. Kalter, Pickas and Lesowitz (1984) provide an example of their recommended group sessions: 1) a group story where the leaders set up a divorce situation; 2) pre-divorce argument psycho-drama; 3-6) group leaders enact focal divorce situations and encourage discussion; 7) divorce newspaper where the children interview each other about their experiences; and 8) wrap up session.

Interestingly the authors cite the most striking aspect of the groups as the readiness of the children to discuss in vivid poignant details their own themes of anxiety; conflictual loyalties; sadness of familial loss and father abuse; excitement and anxiety about mother's dating; and anger towards mother and potential new dad. The children here, as in other trauma groups, retell their stories repeatedly at first and seem to use the peer group interactions to rediscover common bonds and ways to grow (Sonnensheirn-Schneider & Baird, 1980). The divorce groups in schools remained popular throughout the 1980's (Burke & Van de Streak, 1989).

Small Group Process Theory

The study of artificially constructed small groups came into its own with the advent of group psychotherapy. The theory developed in two directions; first from the clinical experience of small psychotherapeutic groups and secondly from experimental laboratory groups designed to specifically observe group process. This research included issues of leadership, decision making, therapy outcome, goal specific behavior, group development and inter-group communication (verbal or non-verbal). Most of this research is molecular in nature. The researchers define specific items and count them from moment to moment. The clinical work is frequently a reporting of sessions with some attention to pre and post membership behavior. There is a debate over interpretation within the clinical literature. The issue is whether the therapists interprets group process or individual psychodynamic concerns or some combination.

Adult Small Group Process Theory

To analyze the thesis question of how groups facilitate the working through of trauma the relevant adult group literature is limited to the development of a group. In the literature group development is also referred to as the group process, the stages or phases of a group. This encompasses the interaction of individuals over time within the framework of a group and contains the implication of growth over time. Whitaker and Lieberman (1964), two of the

leaders in the clinical field of group therapy in the 50's and 60's, sum up this notion well: "group processes are seen to encompass and intersect the individual's concerns in such a way that the individual's therapeutic experience cannot be understood except as it occurs in and through the group process" (1964, p. 269).

The actual delineation of the phases , stages or development of groups has been attempted by a variety of writers. Within the literature there is no agreement as to what is correct or what 'really' happens within a group over time. There is also little work on comparing or categorizing the different systems theoreticians and clinicians have developed. Issacharoff (1981) separated out three models and then ran time limited groups to discover which model best described group process. He concluded all three operated at some point in the life of most groups. However, his categories are worth keeping in mind as a way of placing various theories into a larger framework. The three models Issacharoff identifies are first the linear model where the group moves into a conflict stage and progresses to a stage of cohesive behavior and high task performance. The pendulum model, in contrast, shifts from one mode of functioning to another as it addresses various boundary issues i.e. who belongs in the group, what the discussion should be, how people should talk, what the role of the leader should be etc. The third model is a 'life

cycle model' where the group is time limited and from the beginning concerned with its own ending.

The lab groups or training groups tend to analyze group behavior in an act-by-act manner which may influence their conclusions. Following in the footsteps of the leaders in this field, Bales and Hare, (Bales, 1966; Hare, 1976) groups are viewed as progressing from introductory phases to final solutions in a linear manner. However, the second major influence is the work of Bion (1959) who analyzed group behavior in terms of prevailing cultures (emotions or approaches to the group held by most of the members at a particular time) which shifted back and forth over the life of the group. This seeming conflict between a linear molecular analyzed group and a theoretical understanding of shifts in emotions was circumvented by many in the lab group tradition by placing the shifts into phases. In other words a phase would be propelled forward by the shifts in mood or organization.

Farrell's (1976) lab work identified seven phases that were differentiated by their treatment of five boundary issues. The movement was linear and towards a more valued or 'better' position but within the phases were continually shifting discussion of questions about authority, individuality and autonomy, expression of feelings, disclosure of intimate information and actual analysis of the 'work' of the group. The phases moved from clarifying

boundaries about rules, authority power and intimacy to a period of analyzing group process ending with emergence of unresolved issues and acceptance of group disintegration.

This implicit assumption that groups develop towards a more integrated work related entity is common in the training group literature. Thelen and Dickerman (1961) wrote extensively about their research in the National Training Laboratory in Group Development. They discuss four phases which evolve as the groups realize that the present level of discussion in the phase is not sufficient for good group work. They see the movement pushed by function and then resolution to successively higher levels of organization ending with individual self assessment, flexibility of group process and emphasis upon productivity in problem solving.

Bennis and Shepherd (1961) adopt the internal conflict model as their paradigm for group development. They define development as "the overcoming of obstacles to valid communication among the members or the development of methods for achieving and testing consensus" (1961, p. 321). Phases, in this model, are divided into issues of authority and personal interdependence. Within each of these are three subphases which in turn are split in two as members take opposing sides and then reach resolution on each subphase. Again the movement is towards a higher level of group member engagement ending with accepting differences of

opinion and conflict exist within the group without fear of destroying group process. The members emerge with a greater awareness of their own involvement in a group and the nature of group process.

Long (1984) examined the early development of groups in laboratory situations and discussed a similar process of searching for the nature and meaning of group life. She used the Winnicott image of the group as container with the leader in the mother role structuring the container and helping the members establish the internal and external boundaries of the group. As with the other lab models she found the movement of the group defined by the desires to come together being counteracted by the fears of intimacy and loss of individuality. The splitting occurred on issues of whether the leader could care and nurture the group. The movement was 'good' in that the group ended in an integrated position both having a supportive and containing leadership and retaining a sense of personal identity.

In an analysis of a variety of lab or T groups, Tuckman (1965) delineated four stages shared by the different groups. Again they show movement from fears about intimacy, leadership, and rules towards a cohesive, coherent working group with an emphasis on productive collaboration rather than expression of affect. The values of the group coalesce around openness, tolerance, emotional support and cohesiveness. While Tuckman provided no explanation for

this movement in this direction there is the implication of a group nature that propels people forward towards higher and better forms of group organization.

When the group in question is a therapy group two key elements shift: the membership and issues of treatment. The group members are patients (or clients) rather than interested people or college students. Even though the lab or experimental groups may well contain members with various neuroses or character disorders, their primary reasons for being there was not identified as therapeutic. This initial distinction interjects the issue of movement towards health or greater wholeness in the beginning. The second element is the theoretical split within the clinical community. This split occurs around issues of interpretation, psychodynamic over more behavioral approaches and the role of the leader.

Whitaker and Lieberman (1964) evolved an equilibrium model where the group encounters a flow of themes or focal conflicts. At each encounter the group examines a wish or disturbing motives which they initially respond to with fear. After various false attempts at a solution the group resolves the focal conflict and moves onto another one. The group thus continually works towards equilibrium. The movement continues because the solutions do not last; the group is also working to achieve a reduction in anxiety and a simultaneous high level of satisfaction. The overall

movement of the group is from restrictive solution to more enabling or freeing solutions where more choices and greater independence can exist with less anxiety.

Kellerman (1981), though more interested in deep structures of groups, also sees the movement or process of the group in terms of conflict resolution. With each conflict and its ensuing solution he believes the group elevates its own level of cohesion and consequently deepens the level at which the next conflict will be confronted and resolved. Kellerman is typical of many clinicians writing about group process in his lack of delineated phases or explanation as to how one objectively discover the conflicts or phases.

Some group work is more specific about the particular phases groups undergo as they emerge in conflict resolution which in turn pushes the group to deeper levels of work. Sarri and Galinsky (1974) developed the equilibrium model. They argue that the conflicts emerge when the forces within the group are not in balance because of disagreements about group goals or values. There is a desire to resolve each conflict because of the groups primary concerns with equilibrium thus encouraging individual members to work on each issue so the group can return to a balanced position. Sarri and Galinsky outline seven phases of group development with a steadily increasing level of group cohesion and acceptance of group values or norms. The equilibrium, in

this analysis, develops out of a balancing of the individual needs with the intergroup pressures. The members make several premature attempts at this balance. They seek to deny differences in values and norms until they reach a point where they can tolerate and work with differences. At this point the development of group cohesion no longer means group conformity.

In his work with time limited groups Issacharoff (1981) examined the dilemma of generating cohesion in the face of the groups impending demise. He saw the resistance to cohesion gradually giving way to a cohesive working unit. The group began by questioning whether it could ever satisfy individual needs, attacked the leader and then closed ranks against the therapist. The group then became more open about itself, fears of termination and the therapeutic value of the group. The group ends with a hopeful sense of some good emerging alternating with despair at the inadequacy of the therapist. Issacharoff ended the groups with a didactic discussion of the value of the group.

The descriptions of what happens dynamically in each stage or session are similar in many of these studies. Rather than breaking the groups down by sessions some theorists analyze groups in terms of large phases. Poey (1985), like Issacharoff, described a short term therapy group where the termination date was set at the beginning. He emphasized the need for the development of cohesion in

the group. The movement is from individual dependency concerns to inter-relations among the group members to regression to dependency followed by a final return to the group before termination.

Levine (1979) outlines a four stage sequence of phases which he argues recapitulates social development. Consequently, both the group and the individual move through the phases of development during the course of a group. Bradford (1978) also outlines four phases of groups. However, he does not include a termination phase and envisions these phases as cyclic in nature. They operate on the mechanism which pushes the group to greater depths and individual improvement. Each time the phase begins it is at a more intimate inter-related level. This is more of a cognitive problem solving model but seems to be addressing similar issues of trust, loss and intimacy as the dynamic model.

Both the lab or T groups and the therapeutic groups understand group process as the movement of isolated individuals into some form of collective relationships. Yalom's (1970) descriptions of group developmental sequence includes both therapy and t-groups. He concludes with: "Common sense decrees that a group first deal with the *raison d'être* and boundaries, then with dominance and submission and later as shared experience increases with issues of intimacy and closeness (p. 244). Implicit in these

studies is an assumption that this movement is good for the individuals and that there is some aspect of group nature or force which propels groups into being. The similarities across these studies center on the process of the isolated individuals concerned with authority, intimacy loss and fears about desires for conformity developing into a cohesive group where divergence is tolerated and in fact seen as one of the forces of change.

Child Small Group Process Theory

Though theorists acknowledge children have symbolic abilities and inter psychic issues, there is a tendency to deal cognitively or behaviorally with children that does not happen if an adult expressed a similar wish or fear. This tendency exists in the group work with children emerging in the desire to teach children not to be or feel in certain ways. However, there is a small body of literature which addresses children's groups from a dynamic, developmental point of view. Like the adult work there are few result studies or methodological works. In an exception to this, Corder, Whiteside and Haizlip (1981) compared Q sorts of adults (Yalom's work 1980) with adolescents in therapy. The Q sort was of curative factors in group therapy. The adults and adolescents (13-17) showed similar patterns in their responses except in the area of insight. The authors suggest adolescents may be more defended and less interested in personal insight. The importance of cohesion and

universality emerge in both groups.

The theoretical basis for group work with children is frequently overlooked. Much of the writers on children's groups takes the form of how to manuals. Slavson's (1947; 1950) work in the 40's and 50's remains the primary source for child group work. He argued that a child in a group can experience intrapsychic change because group therapy makes use of the developmental push in latency towards the peer group. Particularly for children, Slavson believed catharsis, release, and transference would occur more readily in the group situations than in an individual treatment (1947,p.26). The effect of universalizing some of the perceived unique experience and feelings also served to reduce anxiety and guilt and thus allows the child to gain equilibrium and a better integration of the self (1950, p. 97). Scheidlinger (1960) argues that groups work because of their "climate of controlled gratification and regression directed by benign adults thus changing the child's perception and expectations of the environment and of the people in it" (1960, p. 367). This ability of groups to provide a space for children to redefine their perceptions of the world, practice new ways of thinking and behaving and a general reduction of fears anxieties and guilt appear frequently in the literature. The realization that one is not unique; that specific seemingly idiosyncratic problems are universal, along with the establishment of a group

culture are frequently cited as the facilitators to better integrated children. (Gawrys and Brown, 1965; Levin, 1982;).

The issue of universality has already been touched upon in the previous sections about post traumatic stress disorder; here we will concentrate on child group culture. For the purpose of this discussion, Erikson (1963) and Winnicott (1967; 1971) provide a useful background. Erikson talks about children developing within social organization and developing systems of meaning with their peers. It is this dual sense of realizing the existence of social relations while creating relationships within a social system that indicates culture is being formed. Winnicott emphasizes the self creating aspect of culture as distinct from a learned or adopted relationship. He sees culture as a continually developing relationship between the self and an even larger and more complex environment. For both Erikson and Winnicott children develop supportive creative cultures.

To bring this directly to therapeutic culture, theorists (Pfeifer & Weinstock-Savoy, 1984; Spinner & Pfeifer, 1986) make an important distinction between indigenous peer culture and therapeutic group culture. They view the latter as the network of meanings agreed upon in a particular group. These meanings emerge from both the therapeutic limits and the children's establishment of

rituals. The group culture then becomes a way to examine the inner world of the children as it comes to represent aspects of this emotional life. The quality of peer culture that is most salient here is its ability to represent both individual and group meanings in one arena. It is within this place of shared meanings that therapeutic work emerges (similar to Winnicott's understanding of play within the holding environment).

The child group work is often approached from a practical rather than a theoretical standpoint. Ohlsen's (1973) compendium includes many reports about the positive effects of groups. Ohlsen starts the work off by dismissing the general misconception that adults believe children are not able to talk in groups. He goes on to demonstrate that children are perfectly capable of discussing their problems and worries, if adults set specific guidelines. There are a variety of studies designed to prove how groups work well for a specific population. Some writers argue groups are the best treatment for minority children because groups are less intrusive, more similar to the children's peer culture, provide more support and act as a buffer to the alien (white) authorities. (Gilbert, 1973; Jeffries, 1973; Lothstein, 1973; Sarvis and Pennekamp, 1970). When there are outcome studies they report children in groups do better than children in control situations. However, there are no standardized systems for referrals, group organization or

pre-and post- group testing to judge particular values of groups (Hammerschmidt & Smaly, 1973; Kranzler, Mayer, Dyer & Munger, 1966; Rose & Edelson, 1987).

The advent of groups specifically designed for children is usually attributed to S.R. Slavson. (Schaefer, Johnson & Wherry, 1982; Schiffer, 1977; Slavson, 1950; Pasnau, Williams & Tallman, 1971). Slavson (1950) argued that children develop through experience and a therapy group can become an experience which effects personality and character change. He designed 'activity therapy groups' where children played with various toys and craft materials and the therapist provide a secure environment for the children to work out their individual difficulties. This 'corrective emotional experience' worked because children still assimilate new experiences which can alter personality and character (Schiffer, 1986). Group interactions were encouraged but not required. Slavson emphasized the importance of children realizing through the group that their problems and feelings are not unique. This universalization then reduced the anxiety and guilt of the child. "Universalization, therefore must be viewed as one of the major contributing factors in activating catharsis, acquiring insight and generally accelerating the therapeutic process in groups" (1950, p. 97).

This theoretical model of change for children remains in the literature but the particular method of therapy; the

activity therapy group, has gone through various shifts as therapists continue to work. These shifts occur across diagnoses, class and race lines. Therapists realized children used talking to solve problems, practice better coping behavior and increased cooperative interaction (Rhodes, 1973). Some groups were begun in the activity group model and then shifted to a verbal model as the therapists discovered that talking increased interaction and a sense of group togetherness (Dannefer, Brown & Epstein, 1975; Epstein & Altman, 1972; Strunk & Witkin, 1974). This group sense emerging from verbal interactions was discovered to be particularly effective for crisis issues and minority youth (Allgeyer, 1970; MacLennon, 1968; Peck & Kaplan, 1966). Moore (1981) found that special education children were able to interpret each other's behavior and encourage better coping outside the group. Talking in the group reduced the anxiety and regressive behavior elicited by free play. Children, like adults, develop group process by listening, talking and comparing problems and potential solutions. Group process; the development of rules, roles and patterns makes possible developmental progression for children (Sands & Golub, 1974).

There is a small body of writing about stages in child therapy groups. I shall briefly examine five of these theories to establish that group process develops in a similar fashion to adult groups. There are no T groups or

laboratory groups for children. When therapists work with children it is within a clinical model. The symptoms of the children range from school behavior problems to impulsive acting out to an isolated crisis.

Trotzer (1989), writing strictly theoretically, argues that child groups began very tentatively with anxiety and ambiguity. Until they develop a basic level of trust children are resistant and present testing of limits behavior. Cohesion develops as the group moves towards acceptance and cooperation. Here the members both accept the group structure and each other as individuals. At this point the group can work on individual problems and the members take on the dual role of helper and the helped. The focus is on the group and its healing capacity. Closure (usually set by the leader) is a time for feedback and group support.

This process of a slow beginning fraught with anxiety is also examined by Siepker, Kandaras, and Lewin (1985). They found children start with questions about why they are members of a group and can the therapist handle their anxieties and fears. As the children begin to internalize the group through a process of understanding the group dynamics and sharing of intense moments the group develops a cohesion which allows the therapeutic work to take place. The members establish rules emphasizing fairness and turn taking. They tell stories and discuss common issues in an

intense group focused manner. The period of termination precipitate separation issues and a return to the members individual problems. The group ends with a movement (goal directed) towards the future following discussion of members changes within the group.

Bonney (1969) and Gazda (1976) both come out of a school guidance counseling group tradition. They view groups as progressing within a developmental model where the children begin as isolated members and gradually form a cohesive working group within which conflicts can be resolved. Bonney and Gazda argue the conflicts in the group and their resolution represent the work of the group and bring about change. Similar to the adult equilibrium models they see, as the members continually approach intimacy or self revelation, anxiety increases and the children become frightened and back off until a higher level of cohesion, trust and mutual support develops at which point group work can progress. Unlike the adult models, Bonney and Gazda emphasize the need for the leader to refocus the group, encourage self disclosure and, at times, work to lower the anxiety level. The leader in a child group is also responsible for helping the group trace its history and individual progress during the termination phase.

Malekoff (1984) predicates his understanding of pre-adolescent group process on the developmental theory that this age child finds group socializing difficult because

they are too old to play as a group and dislike highly personal insight oriented talk. The leader, therefore, must encourage the development of the group through a five step series. The children discover a group purpose, through a cyclical process; as the level of group interaction becomes more intense the group purpose becomes clarified, more defined and sophisticated. This sets off a deeper level of interaction and a reclarification of group purpose. This is followed by a search for common ground among the members whether it be feelings, hobbies, personal styles or life experiences. Through this process group norms develop and the members become aware of their own unique problems while simultaneously realizing the universal quality of their inner crisis. The leader here promotes the use of symbolic language as a tool for working in group. Malekoff includes the importance of playfulness in language, jokes, and in stories for children to be able to interact. Finally he sees this leading to a development of group rituals where the group becomes cohesive and can work.

All of these theories emphasize the necessity of group culture or cohesion for children to be able to work together. They argue for a movement from the isolated frightened individual to a sharing involved group members. Levine (1979) argues that latency age groups are more dependent upon the leader because of developmental push toward uniformity and need more guidance on intimacy and

allowing of divergent opinions. However, they provide no information about the members or about how the particular stages were delineated.

Children's Comprehension of Death

The final section of the literature review addresses the issue of death and children. This is important from three different perspectives. First, there is what children understand death to be from a developmental point of view. Closely connected to this is the issue of what children understand about death after experiencing the death of another (specifically non-familial) child. The final category concerns how theorists explain the process of coming to terms with death.

The developmental line of children's coming to understand death has been established by a variety of studies (Atwood, 1984; Koocher, 1973; Orbach, Talmon, Kederm & Har-Even, 1978; Smilansky, 1987; Speece & Brent, 1992; Speece & Brent, 1984; Wass, 1984; Wass, 1991; White, Elsom & Prawat, 1978). Children understand death at different levels until age nine or ten. By ten an abstract understanding of death exists which encompasses the three concepts of irreversibility, non-functioning of the body and universality. This appears to be true in studies across gender, race and class lines (Balkin, Epstein & Bush, 1976; Raphael, 1983; Townley & Thornberry, 1980; Wass & Towry, 1980).

The issue of experience of or exposure to death and how this effects children's understanding is less clear cut. Within some studies people examined the children with prior death experience as a sub group. Townley and Thornberry (1980) and Childers and Winner (1971) found no consistent pattern in the answers of children with a prior exposure to death that distinguished them from children with no exposure. Interestingly, Florian (1985) discovered one could not find differences in children's answers based on environmental factors until a mature (after ten years of age) understanding of death has developed. Smilansky (1987) found that familial death overwhelmed children and they lost ground on all developmental lines. However, she also found that Israeli children who lived on air bases as opposed to the city did understand death earlier but by ten this difference disappeared. Kane (1979) supports this as well. She interviewed 122 children aged three through twelve and found that a direct experience with death only accelerated death understanding in the children under the age of six.

Children who are suicidal do seem different regardless of age or previous exposure (Koocher, 1974; Orbach & Glaubman, 1985). However it is unclear which occurs first, the immature understanding of death and preoccupation with death thoughts or the suicidal condition. In other words is the fluidity and distortion present in their understanding of death a result of coming to some decision about suicide

or do children who evidence such thoughts run a higher risk of being suicidal. Beyond the work cited in the section on children in school groups dealing with death there is little research on the loss of a classmate or friend (Morgan, 1985).

The third category encompasses the theories of how children respond to a specific death (again non-familial). Most modern grief process theories owe much to the work of Kubler-Ross (1969; 1983). Most succinctly, she proposed a stage theory for coming to terms with death encompassing: denial, anger, bargaining, depression and acceptance. Along these lines Terr (1990) describes four stages in children who have experienced a death: denial, protest, despair, and resolution. The denial stage lasts longer for children, Terr believes, because children have a looser sense of finality or irrevocability than adults. Young children under seven have not yet established a sense of the death as final and older children frequently have a regression to early concepts of death as part of denial. The second stage of protest frequently involves acting out behavior, increases in aggression or the reverse, withdrawal. This behavior is often reserved for school particularly if the death is a familial death. This protest also included a sense of anger both that the death happened around them and at their lack of control over death. The despair stage is the point where children begin to deal with the actual loss

and how the loss has effected their understanding of relationships. The final stage of resolution occur when the child can form new relationships without denying the loss of the old.

The most frequently stated fact in the literature is that there are not many studies about children and death. Valente, Saunders and Street (1988) drew this conclusion and point out that the existing reports do not include control groups of children or adolescence so there are no base lines to even note the effects of death on behavior and affect. In children the cognitive disruption of how the world works (i.e. people are not supposed to die) is counteracted, at first by total denial of the death. They believe that coming to terms with death involves a slow process of recognizing, and then accepting, that a person has died and then learning how to reorganize life taking the disruption of the death into account. This includes both the personal grieving and the social experience (public rituals) that occur following a death.

Johnson and Maile (1987) outline some standard responses children exhibit following a suicide. The survivor responses include: bargaining with God, self degradation for allowing the suicide and continuing to live, guilt reactions, intellectualizing reactions, denial, depression, anger and resentment, loneliness and debilitating sadness. These responses indicate that

children lose the ability to distance themselves from the death of another (particularly a child). This loss is threatening because it opens up the possibility of one's own death. The initial response of total denial and intellectualizing where the death is explained away serve to push the death fears away. The next level where children bargain with God for their own lives, feel personally accountable for the death, angry that it could happen (here both that the person died and that they had to know the person) and then the despair, loneliness and debilitating sadness when the defenses fail.

This double level of anger at the person for dying and then at the self for feeling pain is frequently directed at religion and God as the epitome of a caring nurturing adult. The primary question for God here is why does God 'take' little children? (Glicken, 1978). The small body of literature that addresses these questions concludes that children need to talk about their fears and faith questions because death brings up notions of limits and destroys the childhood fantasies about omnipotence. If God is all powerful then why did God not preserve a child's life. If God is not all powerful than why bother with God. This becomes difficult for adults, many of whom have the same question; a suffering with you God is a difficult religious concept (Bertman, 1982; Grollman, 1977; Heller, 1986; Moss, 1987).

There appears to be a definite process children experience in their encounters with death. I have summarized this developmental process in the following manner: a period of denial both that the death occurred and that it effected them, a move towards overpersonalization, fears about one's own death and responsibility in the death of others and a final period of sadness which seems to come with the acceptance of the death and a reorganizing of how to relate and live in the world in a creative growing manner.

Though there are no specifics about how children go through this process from denial to personalization to sadness/acceptance the clinical reports all recommend letting children talk in groups (Koocher; 1974; Moss, 1987; School Counselor, 1978; Smilansky, 1987). The effect of group work is most powerful around the theme of uniqueness. Similar to group work with emotionally disturbed or disruptive children the realization that one is not alone aids group cohesion and personal recovery. In the work on death this takes on the aspect that death is universal; we all die and we all are vulnerable to having someone we know die (Ryerson, 1977). The additional component of guilt over not dying while another did is also addressed well in groups. The sense of group survivorship and realizing the guilt and fear is normal, not unique reduces the sense of isolation for children (Rickgarn, 1987). It is this

realization that one is not alone that serves to begin the healing process within groups (Parkes & Weiss, 1983).

The final interesting point is the frequently mentioned way in which children talk about death. Specifically children use humor in the form of jokes, puns, stories and movie descriptions to explain their concept of death, fears about death and to establish connections with each other (Fredlund, 1977; Mitchell, 1967; Thomson, 1985; Wolfenstein, 1954). Yalom (1980) describes these jokes about death as part of the 9-12 year olds defense mechanisms. The teasing about death is a way of controlling or tricking death and proving that one can stay alive even after provoking death. This mechanism distances the child from both the actual death and the more general fear of death and this contributes to denial and the now fragile sense that death stays away from children. Thomson (1985) sees the death humor as a way to displace grief, distance the self from the grim reality, and lessen the feelings associated with the loss. Similarly to Yalom, he sees the jokes as attacking death as the child tries to assert control over this newly realized random force.

Summary

This thesis is an attempt to combine information about children and post traumatic stress disorder and group development theory. In light of this; a few points in the literature review now need to be highlighted. These points

delineate what is established or accepted in psychology today.

Post traumatic stress disorder is a disorder children suffer from after a particularly horrific experience. The child can experience severe physical pain or feel threatened by death or can witness harm or death inflicted upon another. In either case the trauma is characterized by a series of specific symptoms. The child experiences the trauma (or death of another) as disorganizing or even destroying an accepted manner of organizing and understanding relations within the world. In the case of comprehending death, children show an initial regression to earlier views about death and then later return to their age appropriate level.

The group theory literature indicates that groups develop in stages. There is a progression within the group towards the members forming a cohesive working unit. Though there is little agreement as to the exact manner of the stages both the adult and child group literature exhibit a similar progression. There is also little data on how greater health in the participants occurs in a group. However the process of becoming a group member is generally accepted as curative.

The literature review opens the possibility of investigating whether children with post traumatic stress disorder can engage in group work. To begin this

investigation it is first necessary to verify the existence of post traumatic stress disorder.

Hypothesis I: I hypothesize it is possible to verify the existence of post traumatic stress disorder in children using a self reporting questionnaire. If one can confirm the disorder it should be possible to determine any change over time, differences in answering style due to exposure to the event or gender.

Hypothesis II: I hypothesize that post traumatic stress disorder in children is responsive to group therapy. The children's participation in therapy involves the development of group identity, i.e. group process. The post traumatic stress disorder group process can be explored to show change over time. According to the literature, involvement in a group over time produces heightened group identity and change in the members.

To test this hypothesis for change over time I measured three different items within the group sessions:

a) topic analysis of member's comments on the continuum

from personal idiosyncratic to group related outside the self statements;

b) reports of post traumatic stress disorder symptomatology; and

c) statements about the understanding of death as permanent, universal and irreversible.

The items were measured by counting over time the number of utterances relating to a) individual or group; b) symptom reporting; and c) death. This method allows for examining change within the group and on a smaller scale differences between individuals, gender and exposure.

Chapter Two
Methodology
Clinical Background

The clinical information for this dissertation emerged from an ad hoc intervention organized by the St. Luke's Hospital Outpatient Child and Adolescent Clinic. The ad hoc nature of the work limited the capacity to collect data in a systematic manner. The time frame of the intervention is important when and why the information for this thesis became available (see Table 1). The precipitating event was a hit and run accident on Friday, January 29th 1988. The driver of the car hit three fourth grade children standing on a traffic island in the middle of Lenox Avenue, killing one instantly, leaving one in a coma and the third in a wheelchair. The dead child's head was smashed in by the car. The accident occurred right after school with a large number of the children's classmates near the street at the time. The driver drove off and was picked up a few days later. The children witnessed police and ambulance arrivals. The funeral held the next week, was attended by about a quarter of the fourth grade. The school is located in a very depressed inner city African American neighborhood with empty buildings and lots surrounding the school. The fourth grade class was a cohesive group with many of the children having been together for two to four years.

The Board of Education sent in consultants from the Emergency Response Team to meet with the teachers, principal and assistant principal (the guidance counselor had died early that January). After the Emergency Response Team met with the teachers they contacted the St. Luke's director of the Social Work Department of the Child and Adolescent Clinic to request assistance for the children in the fourth grade. The children were exhibiting an increase in behavioral problems; verbal and physical fighting and attention difficulties.

The Director of the Social Work Outpatient Unit and the Director of Child Psychiatry assembled a team from the Child and Adolescent Psychiatry Outpatient Clinic on February 8th 1988. On February 10th the team, composed of three psychiatry fellows, two social workers and three psychology interns, met with the two directors, Dr. Kron and Ms. Walters, to plan the next day's initial intervention.

Thursday the 11th of February the entire team met with the principal, the assistant principal and the four fourth grade class-room teachers to explain the plan and enlist their cooperation. The teachers were also given an opportunity to discuss their individual reactions and the ways they had handled their classrooms. The two classes with the children hit by the car had discussed the events, the teachers had been visibly upset in front of their classes. They had devoted time to letter writing, collected

and discussed newspaper articles, attended the funeral service and openly expressed of sadness and anger. The other two teachers minimized the effect of the accident on their classes , though all four reported clear behavioral changes. There were some fears voiced about opening the topic up again and how this would raise anxieties and make the children feel worse.

The actual intervention consisted of introducing ourselves as people from St. Luke's interested in helping children, and commenting on normal reactions to violent accidents. We also told the classes that their principal and teachers felt it might help if we talked to the children about how they were feeling. The classes were divided up into four small groups of 6-8 children with one member of the team working with each group. The children were first asked to draw a picture with at least one person in it. Each group then discussed the pictures (many of which depicted or alluded to the accident). The team leader administered a questionnaire developed by Dr. Kron from the DSM-III-R criteria for post traumatic stress disorder. The group leaders described normal reactions to a trauma and listened to the children's ways of coping. The children were given St. Luke's cards with a name and phone number if they needed to talk more.

After the initial intervention the team met to discuss the small group work and to plan a follow up program. The

questionnaires, pictures and group discussions indicated a majority of the children were preoccupied with and confused by the accident. The three psychology interns and one social worker decided to pursue some form of small group work with the most troubled children. The principal agreed that the children needed more help and endorsed a letter sent to each fourth grade family explaining that groups were being set up for any children still troubled by the accident. On Friday, March 4th the assistant principal agreed to collect the returned letters and call St. Luke's with the number of children interested in pursuing further work. However, she did not do this. Instead, Monday March 7th the three psychology interns and one social worker arrived at the school and discovered the permission slips had not yet been collected (in fact one teacher had not even sent home the letter). The assistant principal had arranged the fourth grade schedule to accommodate our working with each classroom for one half hour. The St. Luke's team decided to meet with each class; re-administer the questionnaire, lead a large group discussion about symptoms and encourage children to return the permission slips if they wished to be members of a group.

The assistant principal did inform the teachers that groups of interested children would be formed to meet on Mondays and set aside two rooms for the St. Luke's teams to use. Monday, March 21st two St. Luke's teams met with their

groups for one hour. The groups came from two different classrooms. The first team, led by two psychology interns had seven children from the classroom where the teacher had said their were no problems. None of the children involved in the accident were from this class. However, one of the children in the group had the identical name as the child who was killed and the class had assumed that she was the dead child for one weekend and had called her a ghost on the Monday after the accident.

The second group was from the class where two of the children involved in the accident were members (one who died and one paralyzed). This was a group of six girls and was led by a psychology intern and a second co-leader. The co-leader varied; a social worker and two different psychiatry fellows were in this role. This group also experienced more room changes and had more children directly effected by the trauma. By the end of March the St. Luke's workers realized from the reports of the girls in this group that they were also in a group led by a school guidance counselor. The process notes were not kept in the same manner. Only the psychology intern kept a continuous record of the sessions. The group agenda varied according to the needs and demands of the children. Some meetings were educational about the nature of death and trauma, others involved picture drawing and story telling. There was also a seance and work on a memorial song and dance routine for the girl who died. Due

to the varied nature of this group and the lack of consistent process notes it was not possible to use it in this study.

The group considered in this work was composed of seven children. They were all in the same fourth grade class. All were African American and the teacher was also African American. There were four girls and three boys. The children had each experienced a previous death in their families. Five of the children's fathers had died (all violently). One child's mother died during the lifetime of the group. One child's mother had either died or had abandoned the family. Four reported deaths of aunts, uncles and a grandfather. One child was burned out of his apartment and moved into a hotel for the homeless halfway through the group. None of the children had previous group experience beyond remedial reading groups.

The group met on the same day at the same time for nine weeks. There were two exceptions to this pattern. One group leader was absent for the second session and her place was taken by another psychology intern. Due to illness the last session was on a Friday not on a Monday. The format of the group did not vary. The group leaders opened the group by explaining they were there to help deal with the children's feeling about the accident and death and the group was a place to discuss their concerns. The children talked in every session except part of the 8th session where

they drew pictures for a goodbye book. The co-leaders both kept running process notes for all the sessions. These notes were then combined to create a record of the group.

At the end of the nine weeks the entire original St. Luke's team went back to the school and re-administered the questionnaire and took part in a memorial service.

Dr. Kron and Ms. Walters supervised the co-leaders weekly in a joint session with the leaders from the other group. The following year 1988-89, Dr. Kron and Ms. Walters met in weekly supervisory sessions with the three psychology interns and the entire set of notes were re-examined, categorized by topic and compared between groups.

The PTSD Questionnaire

As the literature indicates, there is no standardized questionnaire to use with potentially traumatized children. The questionnaire used in this study was developed using the criteria of DSM-III-R and writings of L. Terr. The first order of business was to verify the existence of trauma in this particular event. The premise of this study is that children suffer post traumatic stress disorder after witnessing an horrific out of the ordinary event. The post traumatic stress disorder questionnaire was the tool used to identify the disorder. The questionnaires were examined to see if post traumatic stress disorder in children could be detected by a method of self reporting symptoms and secondly if there were shifts over time in the children's answers.

The particular questionnaire used in this study was designed to determine if the children were showing symptoms of post traumatic stress disorder. The questionnaire used the diagnostic signs in the DSM-II-R's definition of post traumatic stress disorder (see Questionnaire and DSM-III-R definition in Appendix). There was an implicit assumption that witnessing this sudden violent and gruesome accident could produce cases of post traumatic stress disorder. Due to the limitations of naturalistic fieldwork the questionnaire was not collaborated by clinical interviews, parent or teacher reports or subsequent control groups. However, the very limited evidence from other field studies

supports the hypothesis that one can determine the existence of post traumatic stress disorder with a self report questionnaire. It is worth noting that in the adult field both natural disasters/accidents studies (Shore, Tatum & Votlmer, 1986; Smith, North, McCool & Shea, 1990) and Vietnam veteran studies (Fairbanks, Keane & Malloy, 1983; Keane, Caddell & Taylor, 1988; Nolen-Hoeksema & Morrow, 1991; Pitman, Altman & Macklin, 1989) the use of self report questionnaires successfully identifies cases of post traumatic stress disorder. When clinical interviews were used in addition to a questionnaire the interviews confirmed the findings of the questionnaire (Solomon & Benberrishty, 1986).

There are a few studies which examine children's abilities to respond to questionnaires in the event of a situation capable of producing post traumatic stress disorder. In the work of McLeer, Deblinger, Atkins, Foa and Ralphe (1988) sexually abused children and their families were interviewed and observed clinically. The interview included a checklist for post traumatic stress disorder. They were able to match a post traumatic stress disorder diagnosis with the checklist and clinical material. A brief look at four field studies which used questionnaires (none the same) establish that children can use self report questionnaires to established diagnosis.

Klingman (1989) studied tenth graders after a

classmate's suicide and found a significant difference between the children in the class of the suicide case and the other tenth graders. The classmates showed more somatic complaints and more guilt over personal responsibility for the suicide.

In a study (Milgram, Toubiana, Klingman, Raviv & Goldstein, 1988) of a school bus accident where nineteen seventh graders were killed. The children filled out questionnaires one week and nine months after the accident. The authors examined all seventh graders and found some of the children were suffering with post traumatic stress disorder symptoms. The amount of personal loss (knowing the dead children) was highly related to the amount of reported symptoms. There was a significant reduction in the symptoms over time. There was not a significant difference between the exposure levels over time (that is the proximity to the accident). The authors speculate the treatment for the children with greater loss evened out the differences in symptoms.

The Frederick and Pynoos PTSD Reaction Index (Pynoos, et al., 1987; Pynoos & Nader, 1988) has been used with children after accidents and a sniper attack to establish the presence of post traumatic stress disorder. The authors also did clinical interviews to collaborate the validity of the Index's findings.

Saigh's work (1989; 1989a) with Lebanese children

concentrated on establishing post traumatic stress disorder as separate and discernable from phobias, anxiety, depression and control groups (children not referred for help and with no known traumatic events (usually war related stress)). He used four subtests to determine presence or absence of post traumatic stress disorder, the Revised Children's Manifest Anxiety Scale, the Children's Depression Inventory and the Conners Teacher Rating Scale to establish the disorder as diagnosable in children. He found the PTSD instrument correctly classified 84% of the cases previously diagnosed through clinical interviews. The children directly exposed to traumatic situations or those who witnessed another person being traumatized were most likely to be suffering from post traumatic stress disorder. The children with post traumatic stress disorder tested with consistently higher levels of anxiety, depression and misconduct than children with high scores on only one of the other instruments. Saigh's examined groups of 9-12 year olds and 6-9 year olds to establish children's ability to self report post traumatic stress disorder symptoms and the scale's ability to distinguish post traumatic stress disorder as opposed to other disorders.

The Pynoos et al. (1987) study presents the only case where a questionnaire was used in different situations. This may, in part, be due to the nature of studying post traumatic stress disorder in children. Besides Israel,

school systems do not have plans for sudden traumas. The field is so young that mental health workers do not have a ready checklist or questionnaire to hand out after a trauma. Instead people tend to quickly create questions using the DSM-III-R symptom list or conduct clinical interviews.

The Questionnaire was administered in two forms, either 13 questions or 19 questions on three occasions. Unfortunately, the choice of which form to administer was left up to the individuals involved and there were time limitations on the second administration. This inconsistency in length was compounded by the shifts in participation on the administrations caused by normal absences.

There are no exactly comparable studies to compare with this questionnaire. However, a brief review of the research where test retest reliability and individual item correlation were performed indicates it is both valid and possible to examine the information in this manner. The work of Watson, Juba, Manifold, Kucala and Anderson (1991) included a test retest reliability producing a coefficient of .95. The individual item correlation ranged from .47 to .86 with a median of .76. The alpha internal consistency coefficient for the items was .92. The authors conclude their statistics support the theory that the items as a whole are measuring the same construct (post traumatic stress disorder). The Mississippi Scale for Combat Related

Posttraumatic Stress Disorder has also been tested in a similar fashion. (Keane, Caddell & Taylor, 1988). The report a coefficient alpha measure of internal consistency for the entire scale of .94. The individual item total score correlation ranged from .23-.73 with a median of .58.

To address the problem of nonmatching data the questionnaire items were analyzed in a SAS regression model. This allowed all the data to be used in the MANOVA. An r square analysis was used to establish variability. The variables of time, gender, and exposure were examined to determine the nature of the influences on the particular children in this study.

To refine the results I performed a factor analysis of the thirteen question edition. The three administrations were used in the factor analysis to gain the most information over time. MANOVAs were then applied to the factor data to establish difference on questions of time, gender and exposure to trauma.

It is useful here to clarify the usage of a factor analysis in studying post traumatic stress disorder. The actual criteria for post traumatic stress disorder, its etiology and where it belongs in DSM-IV remains an open question. (Wolf & Mosniam, 1990). The connection between symptoms and which particular symptoms are necessary for a diagnosis are still unclear in the literature. A factor analysis of a group of symptoms provide the theoreticians

with new angles to these questions. The items are clustered into groups which can then be analyzed. If the factor analysis can be done over time it is possible to look at the relative strength of different items with any given factor.

A brief look at the post traumatic stress disorder factor analysis literature establishes the background for this work. Most examiners create a questionnaire based on the DSM III-R symptoms and clinical observations. Of the six looked at here, two involved children (Davidson & Foa, 1991; Pynoos, et al., 1987) and the remaining four Vietnam Veterans (Glover, Pelesky, Bruno & Sette, 1990; Keane, Caddell & Taylor, 1988; Silver & Iacona, 1984; Watson, Kucala, Juba, Manifold, Anderson & Anderson, 1991). Due to the differences in scales and amount of information reported in these studies it is not possible to collapse the factors and produce a definitive set of criteria for post traumatic stress disorder. The statistical measures also varied, when reported, making clear cut comparisons difficult. However, there are some conclusions which follow from the comparison of factors. The Vietnam studies all have guilt and adjustment problem factors unlike the child studies. If these are ignored one can globally see three similarities in these factor analysis: intrusive symptoms including nightmares and obsessive thinking about the traumas, sleep problems, concentration and memory difficulties and hyperarousal and thirdly a more diffuse category including

anxiety, depression and foreshortened future.

Group Development

The second hypothesis concerns a shift within the members towards group identity. This movement can be traced through remarks about group and self within the written record of the nine sessions. This category is less clear cut than the questionnaire. It is designed to investigate a shift in issues which in turn illustrate the growth of group identity. Conceptually this means the children were discussing the same major topic (the trauma) but their approach and the verbal vehicles they chose to illuminate the topic altered over time. The literature review established that groups are used frequently for children suffering with post traumatic stress disorder. When the particular trauma effects a school or class groups appear to be the treatment of choice. As noted in the review, there is little work on children and group process or what constitutes the signs of any given stage. However, in the studies, there is a general flow from isolation to group cohesion. Grunebaum and Solomon (1982) state this succinctly;

As a group member, an individual would move from a primitive attachment to the group leader, then to superficial unstable aggregates, towards an identification of self with a cohesive, stable differentiated group culture. (p.300).

In reviewing the group process literature, this movement seems to emerge from setting of rules and patterns for the group. In their work with latency age children in verbal groups Sands and Golub (1974) emphasize the process of children learning to listen to each other, take turns telling and comparing problems as crucial to developing the sense of group belonging. They view this as a progression in the life of the group. Behr (1988) also describes the process of verbal child group therapy and how children reach the point of trust and begin to hear each other's stories and re-pond with their own. He saw the turning point in the group when the children can express sympathy and indignation, and trade stories of gruesome TV shows, horror movies and jokes. At this point groups establish a level of trust to allow more confrontational or interpretative modes of communication. The work of the group is described by many clinicians as occurring in the stage of cohesion. This cohesion stage as delineated by Siepker, Kandaras and Levin (1985) includes telling stories, a sense of fairness, rules about turns, beginning to hear each other, and with intense group focussed discussions.

The problem then is how to measure individualistic unconnected statements, rule setting and group related turn taking behavior. There are many scales used for adult groups which do examine group development. (Fuhriman & Packard, 1986). However, most look at many more different

aspects (i.e content, styles, affect, body language).

The work of Foley and Bonney (1966) analyzed groups by classifying verbal output on the basis of topic and affect. The topics were the following: self, expression of personal feelings, attitudes and concerns, group, discussion of group goals, processes, norms and rules, significant others, things and ideas, intellectual problem oriented concerns or defensive avoidance of the personal. The affect was determined by whether the verbalization was expressing a positive feeling, a negative feeling or no feeling. These classifications were sufficiently separate that raters achieved high levels of agreement. They did a frequency count of the verbal output of each member for each session. They generated data showing changes in the group over time. This particular study was done with college students. A similar process was carried out examining eleven topic categories in groups of 9th graders (Wigell & Ohlsen, 1962). They hypothesized that the self and group categories would increase and the amount of places, persons and things would decrease over time. Though their data pointed in this direction it was not significant. They pointed out that topic and affect can be classified and suggest the verbal output should be broken down by individual.

Group Development Scale

This study uses a simplified classification of Foley and Bonney's self and group. The self category involves

specific statements about the self or family. The child's dream life or eyewitness reports of outside the group events fall into this category. Accident related comments are any direct discussion of the accident, the dead or injured children or attending the funeral of the dead child.

The group category is made up of statements that establish rules and behaviors, statements that are process related statements indicating a relationship or concern about other members. There are direct comments about school, and a large category of stories the children told derived from movies, TV, newspapers or third hand reporting of events. This category consisted primarily of horror stories about death, destruction and mutilation. To fit this category, as opposed to the personal, the events described could not be personally witnessed or involve the self or family members.

To determine the number of comments for each category the sessions were scored by determining the category of the opening statements, counting the number of comments made following it in the same category until a child switched categories. Then the next category is noted and the statements on topic are again counted until the next shift. This method yields the number of comments in each category for each session. It can then be examined by both the number of opening comments and the number of total comments for each category.

Post Traumatic Stress Disorder Symptoms Scale

The symptoms of post traumatic stress disorder in children are catalogued in the DSM-III-R. The diagnosis itself first calls for an event outside of normal human experience, here the car accident. The scale was designed to identify symptoms mentioned in the course of the sessions. Some symptoms in DSM III-R did not appear in the group records probably because of their specific nature and their lack of appropriateness to group discussion. The children's written record of the group were read to locate the references to post traumatic stress disorder symptoms. These symptoms were then counted and organized to determine if there was any change over time in both the number and type of symptom mentioned by the group.

Death Concepts Scale

The specific trauma in this study involved the death of one child (and substantial physical damage to two others). It is important to assess how the experience of a child's death is processed within the trauma work. There is the potential for the trauma to interfere with the grief work particularly in the area of anger and trust. Terr (1991) argued that the trauma's psychic shock interferes with childhood bereavement and one sees mixed symptoms of mourning and trauma. The literature review about children and death established that fourth grade children will have a solid 'adult' understanding of death, that experiencing a

death will cause this understanding to become fluid and that children will go through a similar progression as adults as they process a death. The child's particular concerns about death may shift as the developmental concerns shift but this would not prevent a grieving process from occurring. Schell and Loder-McGough (1979) found the child's focus about death shifts from separation fears (0-5) to mutilation (6-9) to fears about death itself (10 years and over). The focal concerns that the death emphasizes are determined by the age of the child but youth does not prevent a person from grieving. They use the Kubler-Ross stage paradigm in their work. Though there is little literature on non-familial peer death it is clear that a child's sense of omnipotence and trust in the world are shattered by the concretization of childhood death in the event of a child's death.

The children's group work suggests that if children are given the opportunity to talk about death they will. Death conversations are reported in a variety of studies of children's counseling or therapy group (Anthony, 1957; Rhodes, 1973; Moore, 1981; Behr, 1988; Yule & Williams, 1990). These occur in groups that are not necessarily set up around the issue of death as well as groups specifically designed to elicit death topics.

To determine whether children show a regression in their understanding of death and then follow a process as they come to terms with death, the sessions were examined

for specific references to death, dying, dead animals or people, funerals, comments about a particular person who was dead or dying. These statements were found in anecdotes, dream reports, and back and forth conversations between the group members. The actual categories used in the scale were created to reflect the children's topics about death. Using the information in the literature review, the scale is also designed to elicit information about regression in comprehending death and mourning stages. Issues of denial, anger, fear and distress, the children attempts at explaining death, and their recounting of personal experiences with death are thus part of this scale. These references were then categorized to discover if there was an observable pattern concerning comprehension and acceptance of death.

Chapter Three

Results

The results from this study will be presented in the following manner. First I will present the quantitative data regarding Hypothesis I. This tests whether it is possible to verify the existence of post traumatic stress disorder using a questionnaire. I then provide more information on the nature of post traumatic stress disorder as a function of time, exposure and gender. The next section examines Hypothesis II concerning group process. This includes the rating of group cohesion, symptom expression and death verbalization as revealed in the group sessions. The group sessions ratings are more clinical as they draw on the recorded meetings to support the issues raised by the rating system.

Hypothesis I: The Questionnaire

The post traumatic stress disorder questionnaire was designed to measure the presence or absence of the disorder in a child. A positive answer indicates the existence of that particular item within the disorder. A comparison of the questionnaire items and the DSM-III-R criteria (see Appendix) identifies the critical factors for post traumatic stress disorder. As not all of the criteria are covered by the questionnaire and not all the children answered each questionnaire, it is not possible to define precisely which

child had what level of post traumatic stress disorder at a given time. Rather, the questionnaire attempts to provide a sense of post traumatic stress disorder symptomatology that will be analyzed over time. Differences between exposure and gender will also be discussed.

The post traumatic stress disorder questionnaire has one overriding problem for statistical analysis. It is fraught with incomplete data. Producing the same group of children for three separate administrations proved impossible. However, the statistical model used here enabled me to use the maximum number of children from each administration.

The time element represents the three time periods the questionnaire was administered. Time one is before any intervention and two weeks after the traumatic incident. Time two follows the first intervention (small group discussions and administration of the questionnaire) by four weeks. Time three was five months after the original accident and after the two small groups stopped meeting and before a final ceremony for the dead child.

The exposed and unexposed groupings are distinguished by those who saw the accident and or attended the child's funeral and those who were not at the accident site and did not attend the funeral.

The children at each time level and exposure level are also identified along gender lines. This allowed for an

analysis of gender differences for each symptom as well as over time and between exposure levels.

The raw numbers of each administration are found in Table 2.

Items one through nine, eleven and twelve from the questionnaire (see Appendix A) were used in this analysis. Item number ten was dropped because it correlated negatively with the other items and is not a DSM-III-R criterion. Items thirteen through nineteen were not administered consistently at each time or even administered at all at time two. The total r square number was used for a strength of effect test. The r square reached an acceptable point at .65 for all items on the questionnaire. The Questionnaire means and r squares by individual item can be seen in Table 3.

A MANOVA was used for each individual question to allow for comparison between and within groups over time. The Hotelling-Lawley Trace statistic was administered to test for each effect.

Most generally, the time effect and the exposure effect were significant across all items. I will first present the Hotelling-Lawley Trace for the items group and then examine the findings in more detail (see Table 3). The individual questions as a whole had a very significant effect for time, there is a shift towards fewer positive responses over the three administrations. The children showed clear

differences from administration to administration of the questionnaire, answering less positively each time. The exposure effect was also significant though not as high as the time effect. Those children who had closer contact with the trauma consistently reported more positive responses on the questionnaire items. The gender effect as a whole was significant but only one individual item was actually significant, the trend was very slightly towards girls answering more items positively. The specific item where girls differed from boys in the manner they answered will be delineated in the following section. There were three interaction effects; time by exposure, time by gender, and time by exposure by gender. As Table 3 shows only time by exposure was significant.

It is helpful to briefly consider the questionnaire as a whole before examining the individual items and subsequent grouping patterns. As hypothesized children with PTSD symptoms changed dramatically as a factor of time, exposure and gender. Overall, the time effect indicates approximately two thirds of the children initially responded positively to the items. By the final administration there were about one third of the children still citing the presence of post traumatic stress disorder symptoms.

As a whole 61% of the children exposed to the accident responded positively to the questions as compared to 47% of the unexposed children. There was a significant difference

between the two groups. The apparent smallness of this difference may be explained by the close knit nature of this school. Even if one was not in the exposed group there were many opportunities to hear first hand reports of both events.

There was an overall gender effect in the questionnaire. However, as a whole one cannot distinguish the girls' responses from the boys' responses. The one individual item which does differ shows the boys responding higher than the girls.

The time by sex interaction reflects the lack of strength of a gender effect. It is again not possible to distinguish the gender of the children as a determining factor in the manner in which they responded to the questionnaire as a whole.

The time by exposure interaction interestingly, also showed little significant patterns as a whole. Basically, the exposed children responded initially higher and fell less quickly than the unexposed children.

The three way interaction, again because of the general lack of strength of the gender effect, was insignificant.

Effect of time

The Hotelling-Lawley Trace statistic reports dramatic significance for time. When this effect is broken down by item and within item to show change over time (see Table 4-5) the meaning of this statistic becomes clear. Most

concisely the children respond overwhelmingly affirmatively at the first administration. The percent responding in this manner drops at the next two administrations. The children do not respond uniformly to all the questions indicating they are considering the item on its merits. The differences between the questions emerges in how many children initially respond positively and how great a change they report by the third administration.

Items one and six produce similar responses in the children. They question the child's thoughts about the accident and personal worries about accidents or other terrible events that have come up since the accident. Over 90% of the children responded positively to these items on the first administration. If we excluded item seven (to be dealt with separately) these two items show the only non-significant change between the first and second administration, indicating their strength over the children's perceptions of the world. Though these items decrease significantly by the third administration, these are the only two questions still receiving over 50% positive responses.

The items that over three quarters of the children responded positively to also concern thoughts and feelings but are not as related to the immediacy of the incident. Two questioned the ability of the children to keep the accident thoughts out of their heads. Item three dealt

directly with the issue of affect when they did think about the accident and item eight concerned more global thoughts about death and dying issues increasing since the accident. These three items all decrease significantly after two weeks and by the third administration on items two and three only one third of the children report these difficulties. The general concerns about death remain more prevalent at 49%.

The remaining six items follow the pattern of the above three except for two anomalies in items seven and nine. Items four, five, eleven and twelve asked the children about sleep, dreams, concentration and enjoyment of life difficulties. By the third administration, five months after the accident, between two thirds and five sixths of the children were no longer reporting any of these symptoms.

Item seven and nine begin in the same neighborhood of two thirds positive responses and both end with approximately one third positive responses. However as Table 4 and 5 show their routes were quite different. Item seven inquires about separation fears and worries about one's family since the accident does not change from a statistical point of view between the first and second administration. This fear remains a strong force for two thirds of the respondents. Five months later there is the significant decrease to one third positive answers. The question about belief in omens, item nine, produced the

opposite pattern. Two thirds of the children initially expressed a belief in omens about the accident. Four weeks later only one third still believed this and five months later one third maintained this belief.

When the questionnaire was examined for the effect of time the change in symptomatology over time is evident. The rapid shift in four weeks may indicate the effect of the first intervention in alleviating some of the initial high reporting of symptoms. The over all decrease to 30% by five months establishes time as a component in the healing process of post traumatic stress disorder. Without comparison groups or the possibility of further administrations of the questionnaire it is hard to separate out the time element from the effect of the intervention.

Effect of Exposure

An analysis of the exposure issue provides information about the degree of difference exposure had on each item on the questionnaire. The literature on trauma suggests direct exposure to an event should effect a child's subsequent behavior. As I have already noted the close knit nature of this particular community probably contributed to the high unexposed numbers on the individual items. The other possible explanation is the children's normal environment is so stressful and traumatic that the unexposed level represents their normal level of functioning. Even if this was true, the significant difference between the two levels of exposure indicates the trauma effected the children's perceptions of the world in a meaningful manner (see Tables 6 and 7).

Four of the items barely reach significance or show trends towards significance. Interestingly, three of them; one, six, and eight, were the items most children responded positively to on the first administration. These items address the children's thoughts about the accident, personal fears about their own safety, and general concerns about death and dying. Item seven questioned the issue of separation fears since the accident and also shows little to no difference between exposure levels.

The remaining items all exhibited clear differences between those children exposed to the accident or funeral

and those who were not. They fall into a similar pattern as the time effect. The issues and feelings closer to the accident produce higher responses than those more removed. The unexposed children consistently responded significantly lower than their exposed counterparts. There is a much greater difference between the exposed and unexposed children indicating that, having the thought's in one's head, feeling sad or having sleep difficulties the ability to enjoy oneself is seriously hampered by direct exposure to a trauma.

In conclusion it is clear that exposure effects the likelihood of answering affirmatively to the questionnaire. There are differences between the items indicating some items are more influenced by direct exposure. The little difference on some items is probably due to the large amount of second hand information available around this accident. As noted before, there is no pre-accident level to compare with these results.

Effect for Gender

The effect for gender sought to determine if there was a significant difference between the way boys and girls responded on the questionnaire. The raw numbers (Table 2) show there were insignificantly less boys than girls at each time level. It is important to note that the exposed unexposed breakdown within each gender mirrors the totals. This means there were not disproportionately more of one

gender in one exposure level than another. While the overall gender effect was significant at the .05 level the individual items do not show the uniform levels of significance as the exposure and time effects did (Table 8). Ten out of eleven items were non significant. Item three showed a trend towards significance at .07. Item eleven was significant at the .01 level.

Item three involves the issue of feeling sad and crying. The difference between the sexes occurred along stereotypic lines. The girls were more likely to respond positively to a question about affect than the boys (64% as opposed to 47%).

Item eleven which asks about trouble concentrating on school work produced the reverse effect. Here the boys were more likely to have school difficulties (41% to 27%).

The gender effect, though significant over all cancelled itself out on the individual items. The significant item and almost significant item represent the difference in how boys and girls manifest their difficulties. Boys present outward signs while girls have feelings. Interestingly, the only other item nearing significance (.2) with a significant difference between the genders of .06 is the item concerning trouble sleeping. Here boys reported more trouble than girls.

Interaction Effects

The interaction effects, as Table 3 indicates, were not

as strong as the individual effects. The strength of the time effect seemed to influence the time interactions.

Time by Exposure. The time by exposure interaction provides information on the significance of the difference between each exposure level at each time interval. As Table 9 indicates the exposed children usually answered positively at a higher or about the same as the unexposed at time one.

Item two and three are the only significant items. The remaining nine items represent trends rather than a significant difference.

Item two questions the ability of children to get the thoughts of the accident out of their heads. The exposed children at time two and time three had a significantly harder time doing so. This would indicate that exposure to a trauma lasts longer in terms of obsessive thoughts about the trauma. Within four weeks the unexposed children fall below the 50% in this regard.

Item three is the affect question about crying and feeling sad. The same pattern holds here. The change over time is much greater for the unexposed children.

The remaining nine items all follow this pattern though they did not reach significance. The major differences occur in the rapid drop in affirmative responses from time one to time two for the unexposed children. At time three the exposed children drop significantly but there is still a significant (though less strong than time two) difference

between exposed and unexposed children.

Time by Gender. The time by gender interaction did not reach the .05 level of significance.

Exposure by Gender. The exposure by gender interaction did not reach the .05 level of significance.

Time by Exposure by Gender. The three way interaction of time by exposure by gender did not reach the .05 level of significance.

Patterns of Responses

Now that the effects have been examined separately it is possible to group them by patterns of response. This is helpful in understanding if different aspects of the post traumatic stress disorder are linked together or move together over time. In line with other reports of post traumatic stress disorder I ran a factor analysis using the Principal Components method and the Maximum Likelihood test. They both retained one factor with most of the variance explained by one factor. I therefore, determined there was no clear separation of the eleven items into two factors.

There are, however, patterns in the responses. They follow from two aspects of the children's responses. If the highest point and the lowest point are lined up on a grid the following pattern emerges. When this same information is looked at by exposed-unexposed levels and then exposure levels by time (see Tables 10 & 11) the pattern holds together. Item one and six begins with over 90% positive

responses and end with over 50% positive. Items two, three and eight begin with over 75% positive and end with over one third still reporting positively. Items seven and nine range from two thirds to one third. Items four, five, eleven, and twelve begin from one third to one half scores and end with one quarter to one sixth still responding positively. I then looked at these items to determine if the groupings made any sense theoretically. The advantage of groupings is they allow one to analyze the movement of different issues within the diagnosis.

I will now look at each set from a more theoretical standpoint. The first set, item one thinking about the accident, and six, personal fears about safety, emerge as the highest and fall the least over time. They also show the same pattern of exposed children remaining more effected between time one and time two than the unexposed children but both drop by the third time. The linkage between thinking about another child's death from a car accident and the subsequent worries about one's own safety illustrates children's vulnerability in the advent of trauma. The personalization and inability to maintain any distance between the self and other's danger are by products of the trauma.

Items two, three and eight seem to address issues of thinking about or affect about death and the accident. Item eight is in between this level and the previous level. Two

and three are clearly lower than the preceding category yet higher than the following one. Again the unexposed children have an easier time recovering from the presence of these thoughts and affects. The drop is both quicker and further in this category than the preceding one. In all three items the unexposed children are responding at time two in the same way as the exposed children are at time three.

Items four, five, eleven and twelve all address disorganizing aspects in the children's normal life. The trauma acts as an intrusion into their sleep life, ability to function in school and enjoy life. The children report less disturbance in their activities by the third administration. This is particularly true in the area of concentration and enjoying of the self, where the change is 55% to 17% and 54% to 12% respectively. The sleep and dream items show a similar fall, though it is considerably less significant from the second administration to the third. This is striking in that the time sequence was so much less between one and two and yet the children report a very significant reduction in sleep problems and nightmares after only four weeks.

The items seven and nine show a different pattern. Here for the item about separation there is no significant difference between the first two administrations. On the separation question, in fact, the percentage of children increases 65% to 67%. Item number nine about omens does the

reverse. It falls between one and two 61% to 36.5% but then rises insignificantly to 37.4% almost four months later. This brings into question whether omens remain a strong explanation for trauma for the children. The number of children who adopt this defensive style for coping with trauma remains stable over the longer term.

Hypothesis II: Group Process

Hypothesis II concerns the connections between group work and the recovery process of post traumatic stress disorder. As I discussed in the methodology section, the group work took place within the school with a sub group of the children involved in the trauma. There is neither pre-trauma data nor post group follow up available in this field work. Therefore, the evidence about the course of the disorder emerges from the group sessions themselves. The statistical evidence from the questionnaire establishes a change over time for the entire fourth grade present for the administration of the questionnaire (n=111) involved with a particular trauma. The three rating scales give information about a subset of this group (n=7) over time.

Group Process Scale

The group process scale was designed to chart the course of general topics over a nine session period (see Table 12). The methodology section deals more specifically with the choice of topics. To review, the raters distinguished between seven topics: accident related

comments; personal memories, dreams or eyewitness accounts of events; movies, horror stories from TV or newspapers; school comments about teachers, classes or behavior in school; direct statements about other members' well being, presence or absence in the group; rules or specific instructions about how to run the group; and finally group related statements about group process, group feelings, termination and co-leaders behavior. The scale noted the introductory topic and the number of follow up comments. This provides two numbers: the number of times each topic occurred and the amount of back and forth dialogue on each topic. The information about how long they spoke on one topic establishes the actual process of the group. It is important to know that the topic personal occurred twice in a session and there were thirty two responses to the first introduction of a personal subject. The raters agreement on the number of topics was 91% and 88% on the number of topics plus comments. These numbers were sufficiently high to conclude that someone unfamiliar with the group found meaningful distinctions. The numbers and clinical anecdotes used in this work are from my ratings.

Before examining the scale in depth it is helpful to look at some broad issues. Table 13 provides the total number of topics and comments for each session. The sessions fall into three groups. The first three had about half as many topics as the second group though an

insignificantly different number of comments. In other words the children were shifting topics less often. Sessions four to eight average twenty three topics. The sudden increase in comments in session six reflects the intrusion of Nicole's mother's death into the session. This session shifts the general downward movement of sessions one through five. The much lower numbers at session seven warrants the inclusion of session six in the study. The sudden death acts as a temporary repeat of the trauma but does not have a lasting effect on the group movement. Session nine was much shorter than the others because it included a party and eating. Notes were not kept during the party.

The purpose of this group process scale is to discover if there is any shift in the topic choice by the children. The literature suggests that groups move from personal idiosyncratic concerns to group related issues. The scale results support this notion as Table 13 shows the choice of discussion material shifts over time. The numbers of statements in each group were not identical. The percentage of comments in each category for each session provides a better way to analyze the information. The percentages for each topic do change over time. Table 14 provides a graphic illustration of the topics plus comments percentages over the nine sessions. I use the larger numbers of topic plus comments here as it provides a better gauge of the group

concerns. It is possible to see both how an individual topic shifts and its relation to the other topics for an individual session. By examining each category separately the nature of the change begins to emerge.

Accident. The number of comments about the original accident, the precipitating traumatic event, seems surprisingly low. The group did not introduce this topic frequently and did not discuss it for long once it was introduced. After session five the topic did not arise again as a distinguishable item. It was sometimes hinted at but not brought to the surface by the group. Session two marks the height of accident related discussion at 22%. It is not possible to document, but the two class questionnaire administrations prior to the group's starting date may have served as the arena for this discussion. In both administrations the children (including those later placed in the group) freely discussed their presence or absence at the accident and funeral, their feelings and fear surrounding this issue and their memories of the child killed in the accident. The group, as the clinical anecdotes illustrate, seemed self defined as a recovery group and may have viewed the introduction of the topic as regression.

Personal. This topic represents the majority of the conversations in four sessions (one, two, three, and six). The change in this category is most illustrative of all the

categories in the shift of the group concern. There is a rapid drop from session three to four 67% to 13% of the dialogue. The rise to 53% at session six and drop to 15% at session seven illustrates the children's coping mechanisms at times of stress. Nicole's mother's death was handled by returning to personal examples, however the internal movement of the group towards other ways of relating was so strong that the group returns to a 'pre-mother death rate' by the next session. The percentage of just introductory topics shows a similar though less dramatic move. The complete extinction of this topic a session nine denotes the change in the nature of group concerns.

Movie/Horror. This category is in many ways a mirror image of the personal. Here the children discuss events they have seen on TV at the movies or in newspaper. Frequently these are collective or cultural memories. Referring to Freddy Kruger is enough to let all the children feel a certain level of horror. The amount of time spent on movies is low in the first three sessions, reflecting the children trying out ways of relating and the predominance of personal accounts. The absence of this topic in session four may indicate the first attempt to work on group related concerns. The drop in group and rise in movies at session five may indicate the group returning to a safer ground until further development of the group identity. The average of 20% for movies in sessions six, seven and eight

indicates the settling of the group members as they establish a common reference point to illustrate certain events or feelings.

School. The school concerns category is the smallest in this scale. The group brought up this issue in only three sessions and each discussion was short. In session four the school topic first occurs, perhaps as a replacement for movies as it serves the same separate from the personal function. Both are outside the personal familial world and are peer cultural referent point. The overall small number of school discussions stems from the group's self definition. They were not there to complain about school.

Other. This category encompasses comments about each other in terms of group behavior presence or absence and well being. It increased during the first three sessions with an average of 10% for the rest of the group meetings. The one exception again is session six. The 23% at this session reflects the children's concern for each other at the announcement of another death. The difference between the 23% at six and 4% at session one speaks to the increase in group cohesion over time. They were in a different relationship to each other by the sixth session which both allowed and encouraged the expression of concern.

Rules. The rules topic is closely connected to the preceding issue of other. It involves noticing the other but only in reference to prescribing correct behavior within the group. It, therefore, does not include affect. The lack of any of these comments for the first two sessions followed by a gradual increase reflects the groups needs to establish control. By session four and five the members have a clearer idea they wish to convey to each other reflected in the 8% and 13% comments. The drop at six and seven again illustrate the effect of the death where emotional needs take on more importance than the 'correct' running of the group. The final 10% in session eight is the return of control questions particularly in light of the approaching termination.

Group. The group process percentages, like the personal category, most clearly reflects the movement of the group. The sudden increase to 45% at session four is followed by the drop to 19%. This shift has already been noted in the movies explanation. The large amount of group process talk may well have been anxiety provoking making the movie conversations much safer and more conducive to true group growth. The 45% may reflect the group's hopes at group identity with the subsequent lower ratings illustrating the actual state of group cohesion. The session following Nicole's mother's death more accurately exemplify their ability to concentrate on group issues.

Personal or Group. To more generally examine whether there is a shift from the personal to the group it is helpful to combine the topics. Though the topics are different from each other they do collapse into the broader categories of Personal related and Group related. The accident and personal topics make up the first grouping. The accident topic joins with personal here because the recounting of the accident memories are personal. The rest of the topics are group related. The bottom of Table 13 illustrates these two categories numerically. The numbers for introducing the topics are now larger, making their percentages meaningful. However, as the number of continuing comments becomes quite large these percentages still provide the most useful information about the movement of the group. Table 15 establishes the line of change when group topic percentages are charted against the personal topic percentages. The straight diagonal line for both the introduction of topic percentages and the topic plus comments percentages clearly establish the change in the group. When group and personal are charted over time the shift is again very visible. In Table 16 the percentage line of topic introductions for the two categories cross between the second and third sessions. The personal comments go steadily down while the group comments steadily rise. When the continuing comments are including the change more closely reflects the group activity. Table 17 is

characterized by group numbers rising above the personal at session four but falling at session six and then rising dramatically at seven again reflecting the mother's death. All three tables provide convincing graphic evidence of a change in the group's choice of topics. The change is in accordance with Hypothesis II and with the group process literature.

Symptom Scale

The twelve symptoms are drawn from both the DSM-III-R checklist and the literature review of child symptoms (see Table 18). The agreement between raters was 89% for the total number of symptoms reported by each rater. The numbers for the individual symptoms were too low to perform meaningful agreement percentages. The number for each symptom and each session used in the graphs reporting the results come from my ratings. Table 19 denotes the total number of symptoms reported for each session. Table 20 presents the total for each item over three time segments. The time analysis is important in this study. The nine sessions were divided into thirds after examining how the totals for each session emerged and from the theoretical section of the literature review on group process (most succinctly - a beginning phase, a middle working stage, and a termination period).

There is a marked decrease of symptom reporting over time. There appears to be a pattern of very high reporting,

of 39 which then falls by the following week to 19, stays in that neighborhood at 17 then decreases a little and hovers for three sessions and then falls quickly again to 3,2, and 4 for the final three sessions.

The differences between specific symptoms becomes apparent. Fear about one's own safety and concerns about the accident predominate the symptom reporting. It is interesting to compare this to the questionnaire responses. The similarity is clear. This comparison is further enhanced by the change over time graph. Here the diminishing responses over time, though more radical in the sessions are again parallel to the questionnaire. The children responded affirmatively to items on the questionnaire that are no longer appearing in the sessions. The extinction of items within the sessions reflects the real life quality of the group. There is a difference here between the children within the group expressing their concerns and a more passive response to an adult questionnaire. The group leaders did not question the group specifically on symptoms. There are two instances within the group when the children respond to the issue of how the group has helped them by citing the presence or absence of various symptoms.

Clinically, great care was taken to establish the group as a safe and appropriate place for expressing concerns. It seems safe to conclude that the diminution of reporting

symptoms occurred out of a decrease in symptomatology not a squelching of the children's concerns. The group process ratings indicate a progression which allowed for the initial presentation of individual needs followed by a resolution through group cohesion. This lessening of symptoms illustrated in the sessions supports the literature on the healing value of group process.

Death Scale

The death scale included items that elicit a child's comprehension of death (see Table 21). The rater agreement on total death items was 91%. The ratings based on death item are also presented using total scores for sessions and items. Table 22 illustrates the total number of death topics. The intrusion of Nicole's mother's death in session 6 shows up clearly as a peak which then disappears in the subsequent sessions.

The item totals for the death scale illustrates the specific concerns of the children around this topic. The intrusion of this trauma into their lives triggered memories of previous death (both family and others). These two items are the most frequently discussed in the nine sessions. Most of the items fall into the middle range. These are distress or sadness, denial of death, religious explanations, ghosts, fear of one's own or family death and suicidal thoughts. The bottom group with less than five instances are issues surrounding the universality of death,

anger about death and mutilation fears.

The meaning of the children's concerns are best understood by using Table 22 where topic over time is depicted. Here the time element allows for analysis of how the children's concerns about death changed. The sharp increase at session six disappears by session seven. In order to incorporate this rise and fall session six was separated out and made into an individual group. The items then fall into three large patterns. The first group was interrupted by the mother's death but then returns to a pre-interruption level. These items were suicide, ghosts, fear of one's or family death, denial of death and anger. The second pattern indicates greater disruption. Here at session six (the third time element) the death comments reach their high mark and do not fall below the initial number of comments. These items are universality, family death and religious explanations. Here the mother's death seemed to reawake the original trauma of the accident. The third time pattern illustrates a less clear movement. Like the second pattern, the increase of the reporting after Nicole's mother's death continued or increased in the final sessions. As there were only three items (mutilation, other's death, and sadness) each with a slightly different pattern it is hard to draw any conclusions. The sadness and distress item increased over time, perhaps indicating a greater ability to express affect due to the group process

more than an increased feeling of sadness.

Summary

Hypothesis II does hold true in this study. The group work increased, the symptom reporting decreased and the death concepts apparent in the vocalization shifted to age appropriate levels over time. Group work appears to set up the necessary structural mechanisms which allow for trauma work to take place. By moving from the personal to the group the children simultaneously relearn about universalization of responses to trauma and death. This in turn allows for the reintegration necessary to begin healing. Table 23 illustrates all three parts of the hypothesis in relation to time. There is remarkable parallel movements of the group on these issues.

Chapter Four

Clinical Evidence

This chapter illustrates the statistical evidence of the preceding chapter. The clinical data is derived from the nine group sessions. The tables and graphs of the ratings of the sessions indicate the children shift in their subject matter and interactive style. The children's words brings these shifts to life so that it is possible to examine nuances not visible in numbers. The way the children report an event or a symptom, the relationship to the other members, and the effect a statement has upon the group emerge in clinical anecdotes. This analysis is organized around the rating scales to allow for easy comparison with the statistical results.

The group process scale contains seven groupings with various subsection in each larger topic. There is also a certain amount of overlap between the three scales. Rather than repeat the same material I examine subsections of each scale. The symptom scale is illustrated by the symptoms of dreams, sleep disturbances, and no future. The death scale items are the fears of one's own and familial death, the denial of death, the universality of death, religious explanations of death and sad affect about death.

Group Process

The group process scale differs because the content is

important only in what it portrays about the group development. The members used a variety of topics to address the same dilemma. The choice of the topic betrays where the group was located on the continuum of group development. By briefly examining the clinical anecdotes about personal accounts of other events and movie descriptions it is possible to see how both topics serve the same goal. The group discussed rules to institute clarity of purpose or organization. Discussing the co-leaders and issues of termination became the group vehicle to explore coping abilities. These four topics provide a view of the process developing within the group.

Personal Accounts

The first use of personal accounts sets the parameters for the rest of the sessions. The members used these accounts to illustrate their participation in other traumas. In session one immediately following the first discussion of the precipitating accident the following conversation ensued:

Allisha I was walking with another girl and her little brother almost got hit by a bus.

Charles That's the same thing two girls and one boy.

Co-leader You mean like with Nicky (3 children in the original accident)

Charles That was two girls and one boy, here the same you see three for three, the same number.

The way to understand an unexpected accident is to cite other examples and attempt to normalize the experience. The children frequently give two or three examples along a similar theme to establish the lack of uniqueness in horrible events. Post traumatic stress disorder upsets children's ability to normalize and universalize the experience. The recounting of personal events within the group thus begins the reinforcement process. After an indepth description of Allisha's father's funeral and a dead Aunt dream of Tannika's in session one, a set of personal comments emerge as the group tries to determine what is normal:

Javar My father hit my mother so her head was bleeding. When I grow up I'll get my revenge, blow his head away.

Charles Ohhh, Javar is talking revenge.

Daryl Shouldn't talk like that.

Tannika He was probably on crack. My stepfather slapped us all around except my little sister, he's her father. Wanted money from my Mom, nobody likes him no more, my brother say shouldn't let him in anymore.

Charles The day my father hits my mother I'll kill him.

Nicole My aunts live all together now. My uncle used to live with us too and he held up a frying pan

and chased me all around. 'Crazy Man.' I said he should go to Bellvedeer.

Javar Belvue.

Sessions five and six began, after brief opening statements, with disaster stories. These serve to set the tone of the meetings. After discussing Charles' absence and establishing the dates for the next three meetings, Octavia clarified the purpose of the group.

Octavia Anyone here hear about somebody got hit up there around my block. His head busted, I saw him flying up in the air.

Tannika There was a crowd right on the corner. My brother saw somebody acting crazy up there, acting stupid. The police took him to the joint. This man got up in the middle of the street.

The same technique occurs in session six, though the second event is more traumatic (Nicole's mother's death):

Tannika This man in a car all head wrecked up. Ran into a pole on the median. They couldn't get him out. His head trapped, they cut through the car door and did CPR on him and took him to the hospital.

Charles Did you see it?

Tannika I went downstairs when I heard the noise.

Daryl I'm the only person in this room who can stay out late.

Nicole Saturday I was in the house playing with my friend. Grandmother was washing clothes.

Grandmother said you know your mother's not feeling good. The hospital called, she said Mother died, we had to call all over the state.

Charles That's dumb, that's crazy.

The established group format of telling personal events gave Nicole a place and a way to tell her trauma. The rest of session six consists of other children offering verbal comfort to Nicole: Daryl's "I'm sorry to hear that" and others recounting tragic events in their own lives.

This technique faded in popularity as the group cohesion grew. By session eight the children were more likely to interrupt with "You finished?" or to break into a story told by another child. In session eight Octavia tries hard to finish.

Octavia A car jumped into the back yard. They were beating a man up in the back yard. Police came with billy sticks, his guts coming out.

Charles Billy Club.

Javar Billy stick.

Octavia He is white...

Tannika White people really get bloody.

The increased interaction and the push for details both indicate that the personal accounts are no longer useful just as conduits of further trauma information. The group

is more interested in members relating to each others than in relating stories.

Movie/ Horror

The movie topic has a very similar course within the group. It is more removed than the personal trauma. The movies serve as a way to discuss scary topics while establishing a common ground of experience. Both personal stories and movies enhance group cohesion by developing a common framework for the members.

In session three Tannika responds to various stories about mothers dying by citing her concerns for her own mother around the movie theme:

Tannika In Ben Hur these ladies had leopard (leper) skins. Jesus made their skin clean. My mother started crying. I said don't cry Mom I'll be right there with you.

After fighting about Murder on Elm Street and reasons for killing people, the anxiety increased to the extent that when a draft blew the door open the children responded to it:

Daryl Don't do that man, you scared me. That looks like knives.

Allisha Take a chair, I'd hit with a chair.

Nicole I'm used to being powerful, say that to my grandmother.

Tannika (explains about Freddy Kruger sneaking in a

house with knives).

Javar You You...

Tannika There's more about Freddy. She act like she don't want to hear about it. I had trouble going to sleep after that movie.

Daryl When I saw Nightmare I couldn't sleep.

Tannika Lets go on about a new movie.

The group knowledge about scary movies allows the children to discuss their fears in a safe way.

The movies act as an intermediary to the children's response to difficult issues in their own lives. Their inability to successfully use movies in session six illustrates how the anxiety over Nicole's mother's death destroyed one of their technique of coping.

Daryl When my mother die I'm gonna hit my sister.

Allisha A movie...

Charles If everybody die...

Allisha A movie I see...

Octavia I saw this movie too...

Charles Wait are you gonna talk about death?

Here the group tries but cannot even produce a movie title.

In the following session the group does a little better. They introduce the topic of movies right after Nicole tells about her mother's funeral:

Javar Elm Street on TV.

Daryl See another movie I watched And Something Out

There. Amen.

Javar Freddy Kruger on Channel 5.

Daryl Channel 4.

Allisha HBO

Tannika I saw that movie.

Daryl Yeah yeah, (gives a little plot).

Allisha Its scary.

The group spends more time with titles and channels, having considerable trouble arriving at the point: this life is scary and we've all seen scary movies. A little later in this session the group returns to the topic of death after a dream report.

Charles Do you want to talk about death?

Octavia No.

Tannika No.

Charles Do you know what will make us happy?

Allisha Lets talk about a movie in Living Dead.

Allisha offers a little hope, maybe death is not final, at least in the movies we've all seen the dead become alive. They return to this theme a little later and discuss Predator and any movie "with people coming back from the dead". The movies establish a common ground. The particular movies they chose serve to either provide more examples of traumas or hold out the possibility of life.

Rules

The group issued no rules for the first two sessions.

The co-leaders set the original guidelines of sitting down in a group and discussing any issues that were troubling the children since the accident. The rules occur as the group develops to the point that the children begin to set their own parameters of appropriate conversations. When the group develops to the degree that the members feel boundaries the rules become a way to reinforce the group identity. In this group the rule giving took on three forms: negative statements about topic choice; encouragement about topics; and instructions about process.

The negative injunctions about topics are the first form of rules. In session two Tannika says "Don't talk about it" referring to the preceding stories about suicide, guns and death. By session four there is a developing sense of what belongs in the group exemplified by Allisha's comment "We're not here to talk about that". Charles, by session six, is specific about his objection to the jokes with a death theme that were supposed to be cheering up the group; "No more war stories". He succeeds in stopping the joke telling but the group returns to the subject of Nicole's feelings about her mother's death. In session seven the negative statement is more a reflection than an order, though it has the effect of changing the group's direction.

Daryl We ain't doing what we are supposed to do, I
can't say a thing.

Allisha and Tannika begin tearing the covers off books.

Co-leaders comment on behavior and note difficulty

Daryl referred to in his statement.

Allisha We're doing good (writes DOING GOOD on board).

Daryl Who saw Predator?

The group then moves into a discussion about movies with the common theme of people coming back from the dead.

The encouragement rules consist of statements like "You finished" or Nicole's and Allisha's remarks as Charles tries to tell his dream in session four: "Let's get to the point" and "Could you make this short and get to the point". Their injunctions imply there is a point or direction the group is working towards. The group is no longer viewing itself as simply a container for any horror story of any member. They interact with each other and push for connection between the individual comments of members.

The final form of rules reflects this movement. By session five statements like Tannika's "Let's go around and take turns" begin to emerge. Rules about turn taking eventually develop into questions about voting on topics. This became combined with anxieties about termination and the co-leaders habit of taking notes in session eight. Even with the anxiety, the primary motive appears to be establishing control within the group because the group is a separate entity which needs direction and common rules.

Daryl Let's have a vote to see what we're gonna do.

Tannika Write a number

Allisha Need to talk about you..

Co-leaders Worried about what we write

Tannika You know our business not know yours.

Co-leaders What gave you the idea...

Daryl Something to talk about...

Nicole Should have a vote to see how many people want
to talk about voting.

Allisha Now we'll take your paper.

Javar Vote Jesse Jackson.

This shifted into reference about last weeks session and two attempts by Tannika and Allisha to take away the co-leaders pads. Charles ends the uncertainty and 'begins' the group by saying: "Go around, I'll be teacher and call on you". Though he does not do this he succeeded in setting the terms of relating and the group moved on to conversation.

Termination Issues

The group's discussion about termination and the co-leaders reflect the overall development of the group. These comments occur more frequently in the final three sessions. Due to school arrangements there was some talk during session four that session five would be the last meeting. The co-leaders left session four unsure if they could hold the school to the original commitment of nine sessions. This confusion provides some excellent examples of the group's development. The discussion level about termination

in session four is very different from the issues in session eight and nine.

In the false alarm conversation about termination, when the co-leaders could not say whether they could continue, the group was very concrete about their needs:

Allisha I like you all, please don't leave please!

Daryl Let's see that smile on your face

.....

Daryl Uh huh I don't want you to leave. You should pick us up early, said next Monday you won't see us anymore.

Tannika That's gonna be sad, excuse me.

Daryl You should stay till the end of the day, we could get all this off our head, Javar could put his baseball bat away, Nicole could stop crying, Tannika could tell her stepfather to go to the crazyhouse.

The group continues with each member repeating various symptoms and fears.

Charles Everybody who wants to stay say AYE!

All AYE!

At the end of this session the group returns to the question of the co-leaders being able to continue the group as promised.

Tannika What I want is for you to talk not us.

Daryl Two of us take the papers and you two talk not

us. And you two not write and you can tell us what you think about us.

Charles You love us...

Nicole What it is you all feeling about us?

Charles They love us. (Sings) 'Start Spreading the News!'

Javar (sings) 'I'm a New York Kind of Guy!'

All sing 'Leaving on a Jet Plane, Don't Know When I'll Be Back Again!'

By session five the co-leaders straightened out the schedule and explained how they could stay for five more meetings. The anxiety about the co-leaders ability to keep the meeting dates re-surface in session seven. The group's teacher, Ms. H, was absent and the class was split up into other third and fourth grade classes. The first ten minutes were spent trying to locate the group members. The children were very anxious about finding everyone and had difficulty in the beginning of the session talking as a group:

Tannika Ms. H backward, should have told you where we were, can't wait till June.

Allisha I heard her...

Javar I heard her tell Miss L. she wasn't coming today. Some group movie talk, co-leaders asks if group thought the co-leaders were coming.

Daryl No, Yeah I thought you going to come.

Tannika Thought you was coming.

Daryl I told...

Charles She come before, she'll come again.

After more movie conversation the first negatively directed comments about the co-leaders occurred:

Tannika You got a husband?

Daryl Why don't you tell us about yourself?

Tannika We won't judge.

Co-leaders Make connections to session four and termination.

Tannika I know you'll say don't want to talk about that, You want to know what's inside us. Now you tell us about you. You might be a strange man dressed up like St. Luke's ladies.

Javar That's right.

The group expressed approval of this idea and then shortly returned to the question of why the group was ending in two sessions.

Tannika Not coming anymore, don't like us. If you don't like us call us a brat.

They discussed why they were meeting but soon return to the co-leaders:

Allisha Are you mad at us?

Co-leader Why?

Allisha Cause we weren't talking about what we were supposed to.

Co-leader This is your time.

Tannika I think you think we're stupid, think we're
pain in the neck.

Daryl Next time we can talk about sex ed. A lot of
that is on my mind.

Tannika About what's going on in my body, You work in
a hospital right?

.....

Charles They got more to say than us, the kids you see
at St. Luke's. Like them better, they smarter
than us.

Tannika We act like jerks.

This theme of the co-leaders leaving the group for others
reappears at the end of this session:

Javar First, I want a party. I know you have to go
take care of other people.

Allisha He sounds like white people.

Javar You have to take care of kids that's why you
don't have time to be here.

The link between the group ending and the children's
belief that they were not good enough remained in the
background of the termination process. The slight hint that
being white might effect the co-leaders is not followed up
by the group. Trauma sufferers already feel they are bad or
less able to handle life serving to further enhance this
feeling of being jerks. Daryl explained this dilemma in the
final session; "My teacher say why are you all having a

party, it ain't nothing but talking about people who are dead". The point of the group is silly and their response to the trauma is extreme seemed to be one of the children's messages to the co-leaders.

The flip side of the termination, the sense of accomplishment and growth emerges in the members' comments about caring for the co-leaders if they ever need help. It also can be seen in their expressions of trust in the co-leaders. Due to unavoidable circumstances the final session had to be moved from Monday to Friday. The group recounted how they ate the treats they had brought for Monday. The group discuss how one member was absent or playing hookey. The co-leaders asked if the group believed Monday's absence was the co-leaders playing hookey. (They had in fact been told one co-leader was sick).

Daryl Doing important work.

Allisha Something important came up.

Nicole Sick.

Charles Coming on Friday I heard that.

Javar You'd never play hookey.

Co-leaders Couldn't come because of illness.

The group ends with various expressions of wanting to keep the group together, of a family feeling to the group. There were no recitations of symptoms or anger at the ending. The sadness and fantasied wish for staying together seemed appropriate to the situation and reflected the individual

members' growth as a group as well as the diminution of symptomatology.

Symptom Scale

The clinical description of symptoms supplements the information in the comparison tables between this scale and the questionnaire and the shifts over time both scales exhibit. A sample of the items will be examined using clinical data. These represent different patterns and styles of reporting designed to give a picture of the children's use of the group to discuss their symptom. The following clinical examples illustrate how these differences manifested themselves in the sessions.

Dream reporting

As the literature review indicated, dreams are a frequent method people use to deal with and denote the existence of post traumatic stress disorder. The dream symptomatology occurred in two ways in the sessions. Some children gave descriptions of the dreams and answered follow up questions. At other times the dream was simply introduced by its content and then dropped. There appears to be no order to which form the children used in that both forms appear throughout the sessions. The fact that they chose to report dreams supports the theory that the group can be a safe environment for such expression. In using dreams as a method to explain their feelings the children lend credence to the theory that dreams play a large role in

children's experience of post traumatic stress disorder. The dream memory is thus both a vehicle for working through the anxieties caused by the trauma and a illustration of the problem when they are unresolved nightmares.

The first dreams appear after approximately ten minutes of the first session thus establishing the group as a place to introduce such material. After the children described their experience of the accident and a further discussion of other near accidents, Nicole reports a long dream about cars chasing her, ending with,

and then I was stuck on the street with cars and busses running around me going by very fast.

This is a clear reference to the accident: the children who were killed were on a traffic island between two lines of busy traffic. The children in the group treat the dream report as more data about accidents and continue to report on their personal experience of traffic accidents. Towards the end of this first session the children begin discussing ways to stay asleep after the trauma. Nicole uses this as a forum to discuss her fears of nightmares including the one she had reported earlier.

My sister who goes to college called and talked to me. "Bible, (sleeping with a Bible has just been suggested as a method to avoid sleep difficulties) you better work. If I woke up with more dreams I'll start throwing everything, even my lamp,

across the floor...

In session two, the other form of dream reporting took place. Here one dream topic, followed by three more, illustrate the children's continued fears generated by the accident:

Nicole I had a dream I was lying in a coffin in my church asking myself questions. I woke up crying grandmother'.

Allisha I had a dream a mouse was crawling on me.

Daryl A spider a crawling on my leg.

Tannika At church they say God gonna come and take all the good children the bad go to the devil.

Daryl I had a dream I was hit by the car and broke my legs.

A little further in this session Allisha reports a dream about her Aunt trying to strike herself and Charles says he had a dream about Freddy Kruger. The dreams are thus reflecting their anxiety and are woven into the discussion. Death can be discussed as a memory of a father dying or as a dream about an Aunt trying to kill herself. The dreams are another vehicle for personal revelation within the group.

This close connection between death, trauma, and dreams is explicit in session three. Directly following a conversation about the death of parents and the permanence of death, Daryl reports, "I died in a dream and never woke up. I saw a movie like that where a boy's face was all

messed up". Here he is both connecting death to sleep and opening the possibility of his own death. He uses both a dream and a movie to establish his point. In an answer to a direct question about the usefulness of the group Allisha reports that she has, "No more nightmares". There is no disagreement with her over the presence of nightmares or their validity as a symptom of post traumatic stress disorder.

In session four there is a shift in the response to the dream. The dreams are more group related and elicit group response. The children are no longer simply presenting evidence with dreams as one form of evidence as Daryl did. Now they comment on the dreams as a method of developing group cohesion. Charles even dreams about another child in the group, enhancing the feeling of relatedness. After complaining about how they cannot recover from the trauma and how they are meeting in the 'wrong' room, Charles begins to describe his dream:

Charles I dreamed me and Daryl went to the movies-

Robocop

Allisha Disgusting

Charles We got popcorn, the fat foot man showed up
and dug his head. And he took them through the
back in my kitchen. We was sleeping in the air.

Allisha Could you make this short and get to the
point.

Tannika I thought this would be an adventure like what
Daryl said about the gun.

Charles The fat foot man in the kitchen woke up my
man, my father

Tannika I want to laugh about the story. This is not
funny.

Allisha Not here to laugh.

Charles I'm trying to finish.

Tannika Then finish

Charles The fat man was in the refrigerator. Then I
waked up and my father in the kitchen and he was
eating everything.

Lots of yelling and complaining from the group. Here
the shift in both dream content and group response is
obvious. The dream initially involves another child, then
switches to fears about safety and nurturance (in the image
of first the fat foot man and then his father eating all the
food). The group attempts to organize each others responses
and is developing rules about how to present information.

Later in this same session the children present the
only incidence of three dream sequences connected with group
response. Though alone, it most clearly elucidates the use
of dreams as a personal vehicle for the expression of
anxiety and as a group vehicle to build up the group. This
section occurs right after Javar retells his version of the
original accident:

Nicole ... I had a dream my mother died and the uncle moved out. Friends came to the house, Miss Teacher called and asked why I don't come to school, came and took me out of the house. My sister locked in the house, now me and my sister back home.

Daryl You went to Miss Teacher's house?

Javar You went to Miss Teacher's house?

Allisha 'On top of spaghetti all covered with cheese...'

Tannika (covers her ears)

Daryl One night dream that Freddy Kruger came and my father die.

Allisha I can't hear, (sings louder) my ears about to fall off.

Daryl Not about Freddy, in the dream see through her a dream about Nicky, there she goes (points up) lying in bed dream I'm seeing Nicky invisible see through her her talking not able to hear.

Co-leaders What did she say to you.

Daryl Why I die? See there she goes (points)

Octavia (looks)

Daryl I want to sit by Allisha.

Co-leader What did she do

Daryl She was just talking why me why did she have to die.

Allisha Sandy are you mad?

Nicole I'm going to bed

Javar I had a funny dream, nightmare, at night. I was in the jungle like Tarzan jumping over ropes into the white thing you know (fog). Every time I come out a different person everybody called me Tarzan. Woke up laughing.

The incidence and elaboration of dream reporting fall after this illustration. In sessions six and seven Daryl and Tannika each report, without follow up, a dream about a Grandmother dying. The final dream reported by the group represents the shift from the personal to the group. After discussing the goodbye party planned for the last session Allisha reports, "I had a dream about you having a party without me, and a dream about caring for Sandy and Elizabeth". Again there is no clear group response and no further eliciting of dreams.

Dreams, as a symptom of post traumatic stress disorder, can serve as a way to chart children's progress towards healing or reintegrating. The ease with which the children reported and discussed dreams adds to their value as a way to investigate the well being of the children. It is not just the lessening of reports but the content and the involvement of the group that indicates the children's growth.

Sleep disturbance

The symptom of sleep disturbance takes on a variety of forms for children. The most common complaint of dreams is covered in the above section. Children report the dual problem of having difficulty both in falling asleep and staying asleep because they fear something bad will happen to them while they are asleep. As a corollary to this fear, children frequently can no longer sleep alone. As Daryl says us "I sleep with my father cause he has lots of guns...". Sleep is also seen as a time of potential danger to other family members. Children report fears about what will happen to others when everyone is asleep. The unconscious connection between sleep and death also emerges as these children lose their developmentally appropriate understanding of death's finality and separation from life. This loss of the sleep and death boundary shows up in Tannika's first dream, reported in the first session,

I had a dream that my Aunt, who lived in Virginia, she died already, but while I was asleep she shot me. Everything was all backwards. She cut out all the lights shot me but missed me, chased all over the house, locked me in a room, so hot I suffocated.

Each of these expressions of sleep disturbance are found in the group sessions.

The sleep disturbance the children bring up in the first session expresses their concerns. They are afraid to

sleep because someone in the family might die and they need some way to stay asleep safely. The traumatic disturbance of normal trust, a sense of safety, and the assumption of adult caretaking presence are obvious in the following examples:

Nicole My grandmother hit me. I sit watching my grandmother, make sure she breathing when she's asleep afraid she's going to die.

Allisha I talk to my grandmother on the phone, I say grandma...

Tannika I'm scared Mom will die in her sleep, I wake up and check her at night a lot. Mom has a knife under her bed cause of stepfather.

Octavia My Aunt her baby died. My mother had twins, go feel them at night, see if they are breathing. My Mom reads me the Bible, helps me go to sleep.

Charles This is a matter of life and death.

Co-leaders comment on seriousness of conversation.

Nicole Grandmother said I should sleep with a Bible.

Got one that is so big takes up the whole bed.

Javar Charles and Daryl discuss the size of the Bible.

Here the children exhibit real fears about the dangers of sleep and their limited abilities to find safety.

By session three they seem more active in protecting themselves from the dangers of sleep, though the connection to death and danger remains quite strong. After a

particularly gruesome story of an accident ending with, "Now she's paralyzed with her eyes open," there is an immediate response illustrating the group's confusion and fears about sleep and death.

Charles I sleep with my eyes open.

Javar I do.

Daryl I do.

Nicole How can dead people have their eyes open? By sleeping with their eyes open the children are actively attempting to stave off death and sleep at the same time. In a more elaborate form Javar explains this phenomenon (following Octavia's story about her aunt killing her cousin).

Javar My mom put out all the lights at night. I keep my bat next to the bed.

Tannika Excuse me, does she cut out the bathroom light?

Javar No.

Charles My mother leaves on the kitchen light.

Javar My dog would bark, I take a bat to bed.

Nicole I was at Nicky's funeral, after she died, was crying and crying, someone fainted. I was crying like mad, got into bed with Grandmother...

Here adults are providing a little safety. At the end of this session three children cite sleep problems as evidence that they continue to need the group meetings:

Daryl Still sleeping with my father.

Javar Still sleeping with my bat.

Charles Still sleeping with my bbgun.

It is clear that the group link their sleep problems to the trauma. Their attempts to counter these problems are seen as signs of their well being.

There is a shift by the next meeting. Sleep problems were not brought up except to indicate that they were changing to a pre-trauma pattern. This occurred when the subject of group termination surfaced followed by a brief conversation about pet death.

Daryl I sleep with my Uncle since Nicky's death, not before. After tonight I'm going to try and sleep in my own bed.

After a return to termination, Javar comes back to Daryl's point:

Javar My mother has to break me of sleeping with my bat cause I don't know what might happen. The dog might get hurt when I hear a noise and hit with my bat, or my cousin.

Session five is the extinction point for sleep disturbance. Here they make the transition from a symptom to a vehicle describing feelings. This transition does not appear to be very strong as both symptom and vehicle do not appear again in the sessions. The children use the inability to sleep as a means to indicate the frightening quality of a movie. The

underlying link is from the trauma to the scary movie. This occurred in three unrelated times in session five. In the midst of a 'Freddy' description Tannika says "I had trouble going to sleep after that movie". A little later Nicole reports that she "saw a movie and got scared and not able to sleep. Grandmother was asleep. I pulled her arm cause afraid she'd die..." Allisha returns to the 'Freddy' theme a little further on, "My cousin come to spend the night with me. She said please stay up with me I'm scared of Freddy. My cousin went to sleep, I stayed up all night..."

The theme of sleep disturbance does not appear again in this group, though there is a significant concentration on sleep that took place in the closing five minutes of the final session:

Daryl (to Sandy) You all got an extra bedroom?

Allisha Why do you say that?

Daryl I want to go to sleep there. I wish you all could just come here and stay until the year's over. Now since you been here, I don't want to leave please, like grandmother. You're like family to me.

The final discussion of sleep is thus group related. The merger with the group leaders echoes the move Allisha makes in her final dream of caring for Sandy and Elizabeth.

No future

The symptom of 'no future' as delineated by Lenore Terr in the literature review is part of children's perception of being traumatized. The group indicated this symptom in two ways. The clearest evidence is the end of the world statements which eliminate a future for everyone. The children also establish this system of explaining the world when they deny their own future or growing up and becoming adults. Part of the return to health or reintegration in the children's experiences can be seen in the shift regarding the future. The symptom of having no future disappears by session seven. It is important to follow the movement of having a future to understand the nature of this symptom.

The group shows complete agreement during their first discussion on this topic in session two:

Charles Everybody gonna die.

Nicole By the first of May.

Octavia Doomsday is a coming.

Allisha Not till my birthday.

Tannika I don't want to die.

Allisha God wants us to die for Him.

Daryl Just little girls.

Allisha My cousin died last year.

Octavia At doomsday the world gonna blow up.

This clear global lack of future was personalized in session

three and merged with the notion of care taking. The dominant concern that children are not cared for by adults or God and the children's inability to care for themselves emerges in the following selection:

Nicole Got a bone stuck in my throat, God wants to take me. I don't want to have a baby.

Javar Once my father and mother fight.

Octavia Some kids not careful and make a mistake and shoot themselves.

By session four the children are less unified on this feeling of having no possibility of living into adulthood. When Nicole says "I don't have a life now" the group responds "Leave that (the accident) in the past", "Let the past stay where it is, lets talk about our life". This is reinforced in session six after Nicole discusses her mother's death and comments she want to be with her mother's spirit. Tannika cautions her in a shift from the early doomsday language "If I was you I won't kill myself, I just miss my mother."

In a more indirect manner Daryl indicates his personal movement from a traumatized lack of future to a sense of life when he comments at the end of session seven: "Next time we can talk about sex ed, a lot of that is on my mind". The hope for a future emerges around the topic of termination in session eight. Here children who had been forecasting the end of the world begin to project into the

future:

Javar Stay till June next year after the next year.

Nicole Not for me. I'll come with Grandmother to see
you after Grandmother goes down south.

Tannika Why not come till July?

The group repeats this theme even more vehemently at the end
of session eight:

Tannika Come while we're in school

Allisha Till we get old.

Javar Till we have families.

Charles Daryl will be playing basketball.

Here the shift is complete. The group envisions staying
alive, growing old, having families and careers. The
symptom of no future does appear in their lives after the
trauma but is apparently not permanent and shows abatement
during a group experience.

Summary

The clinical anecdotes of symptoms gives important
information in three areas not accessible from
questionnaires or clinical interviews. The sessions provide
evidence that children will present symptoms in group
discussion. By tracing the symptom presentations it is
possible to see change over time. Finally the children use
symptoms as vehicles to discuss their well being and
feelings within a group.

Death Scale

The death scale was designed to measure the children's naturally occurring comments about death within the group sessions. In presenting the clinical material it is helpful to review the Tables on the death scale and the section in the literature review on children and death. The clinical anecdotes are derived from a subset of items on the scale.

The topic of death occurred in three broad categories in the group. As the trauma was a death, discussing this death and then memories of past deaths or fears of future deaths represent the largest category. If this first category is called concrete or actual death then the second is on a more existential level. Here the children discussed death itself: what death is, how you know what the properties of death are, and the how and why of death. The third form the group used in discussing death is the more amorphous emotions generated by death. The distress and sadness they felt about this death, other deaths or separations were rarely directly stated. The stories were full of anguish but most of the evidence for affect must be inferred.

Fear of own death

The item 'fear of one's own death' was expressed in two ways. The most basic method was the direct statement which occurs early in the first session when Octavia states, "I'm scared of death". These direct statements appear throughout

the first six sessions. The more common experience of this fear took the form of various children reciting frightening events that could happen to children.

An underlying lack of trust in the environment emerges in these discussions. The trauma of a child randomly killed by a drunk driver combined with the objectively dangerous neighborhood the children lived in temporarily destroyed the children's beliefs in safety and trust. There are no pre-trauma measures in this study so it is not possible to prove this is a new way of understanding the world as dangerous and life threatening. However, there are three pieces of clinical information that support this conclusion. When the children list the disasters and dangers, they are in complete accord indicating some similar experiences is influencing the conversation. The quality of the presentation is of a driven and intense nature. Finally this topic disappears after the sixth session. As it is unlikely the group could freely discuss dangers to children for six sessions and then stop for some external pressure it is more likely the beliefs were no longer as strong or dominate in their thoughts. The increase in discussing ways to stay safe supports the idea of naturally diminishing of interest in this topic. The statistics on the questionnaire also lend credence to this theory. The following examples illustrate the forms these discussions took:

Charles That day (the day of the accident) and every

day have to check the light and be careful. My little sister gets wild (story about her not listening) and almost got hit.

Javar Yeah, she wild. She was coming down the ramp and almost got hit the same day as the accident.

Daryl And you have to watch out for people driving in case they don't watch the lights.

Charles Or if they turn fast.

Octavia Some people might shoot you.

Here the feeling of vulnerability and lack of anyone to help these children is apparent. In response to Nicole's question 'why are we here anyway?' the co-leaders asked the children how they felt the group was helping them. This led to a litany of ways to stay safe, indicating how dangerous the world is:

Charles Helped me learning not to be running in front of the car, teaches me to stay in my house.

Daryl Be safe in home with four locks.

Tannika She (her mother) barricades the door.

Daryl And locks the windows.

Tannika Need gates.

Daryl Children gates on the windows.

Charles My grandmother has a 38.

Daryl Iron door from my mother.

Charles Like the door where you have to turn knobs.

Octavia Scared of my own death it might be in a

shocking way, don't want to die in a shocking way,
reading the Bible to stop it.

Charles Had a dream about death.

Tannika Born in this world to die.

Allisha Not safe nowhere with bombs.

Charles Safe with four locks.

Daryl Not in the penthouse, climb up and get you.

Allisha Or throw the bomb on it.

Tannika Ever see a man sticking his head out the
window pull down the shades.

Allisha Not look out the windows, not safe.

Charles My big brother almost jumped out the window.

The co-leaders question about help is thus quickly subverted to the children's primary concern: the lack of safety in their environment. They try citing ways to stay safe but end up raising the disaster quotient. These direct discussions about personal dangers diminish over time as the discussions shift to dangers to others or dangers in movies.

Family death

The children discussed their family members' deaths from the very beginning of the group. Similar to their use of dreams, they used their previous experiences with death to explain how death happens, what funerals are like, how people respond to death and ways to help recover. The advent of Nicole's mother's death in session six reinforces this pattern of previous death experiences serving as the

bridge to the present experience. This allows for an integration of the death into one's world view and a movement away from personal experience towards cultural experience (i.e. movies, T.V., or horror stories).

This was the largest topic on the death scale indicating the importance the children placed on previous personal experiences. A few examples from the sessions illustrate the nature of this conversation form. In a long group discussion which began with a fear of shooting, Allisha seeks to explain her father's death and its consequences. The comments between Allisha's statements include other children's funeral and death experiences. Allisha's comments, placed together, illuminate how the children describe their own experience.

My father got shot in the back. A 15 year old shot him cause (when) he was getting me a Cabbage Patch.

.....

That was my first funeral, that's why I hate them.

...

I'm scared they will jump out of the coffin and not be dead.

...

Day my dad died not want to cry. I went to school and not cry but at the funeral when my Mom kissed him, I cried and was shaking and when they put flowers on the coffin. He was only 31, cried in the car.

...

I was sacred at first (when told and unable to cry) and went to bed and sat.

After establishing that people do die and those left feel sad the group sought to figure out what could be done next. The first form these solutions took was a description of how other's responded.

Session two includes a variety of these explanations none of which seemed to comfort or help the group:

Daryl My mother wanted to kill herself after my father was killed.

...

Charles My father, uncle, no father, got shot in the head six times. My uncle told me my mother tried to take pills.

...

Nicole When my aunt died my uncle started tiptoeing around. (implication was he went crazy)

These bleak pronouncements stand in sharp contrast to the empathy the group expresses towards Nicole after her mother's death. In session seven one of the co-leaders asks Nicole a question:

Daryl Leave her alone.

Tannika Leave her alone, she's thinking. Nicky do you want to talk?

Nicole No.

Tannika Daryl see Nicole not want to talk. If your Mom died you'd be crying. If parents died people look at them cause their parent died.

Charles When my father died people teased me.

(all discuss which parent they need or talk to more)

Tannika Its so dead in this room.

Daryl Need more action.

Tannika We're here to talk right.

The understanding of Nicole's distress seems real. The children were able to explain the situation without being overwhelmed by disaster. Tannika's final prescription to talk as the needed action is repeated by Allisha in session eight. She speaks directly to the co-leaders:

If something is wrong with you, we could be your counselors. If someone dies in your family we'd be your counselors.

The connection between death and vulnerability to disaster has been replaced by death and empathic talking.

The four items on the scale linked to the death comprehension literature are denial of permanence, universality of death, explanations for death (here all religious) and distress or sadness about death. The literature suggests that a trauma will create temporary regression in children's understanding of the permanence and universality of death. Typically children seek explanations for people's deaths in their own actions or in the dead

person's life. The children here use only religious explanations for death. The common cultural heritage of the African-American church provided a background for the group to investigate death. The expression of affect is associated with an acceptance of death and is seen in children after denial and anger. The clinical examples from the sessions are both less frequent and sometimes less obvious in these categories. However, they do provide an insight into children's comprehension of death not available from a questionnaire or scale.

Denial of permanence

The denial of the permanence of death takes on various forms. The most apparent are those like Allisha's previously cited remarks "I'm scared they will jump out of the coffin and not be dead." A little later on in the first session Allisha reinforces this fear with a newspaper story. The group adds further doubt to the finality of death:

Allisha In the newspaper they said there was a dead man who woke up. If I was working in a funeral home I'd be the first one to leave.

Daryl How could dead men get up?

Charles Zombies!

Javar God give you another chance.

Tannika My aunt came over. She used to have seizures, had one went to the hospital and now she's retarded or something.

Javar My aunt came over tells me a story, Nicole might come back.

Tannika Like a spirit?

Javar No, like you.

The possibility of the dead returning is also confused with the exact nature of death. Tannika is making an analogy to a form of death in her aunt who 'is retarded or something'. In session three Javar makes a similar statement about paralysis and death.

Javar My aunt's boyfriend always fight her. My aunt prayed and he went out and got hit and now he's paralyzed, a vegetable, frozen legs, dead.

Tannika, Nicole and Octavia discuss whether paralyzed means dead or not.

Tannika If I rolled down a hill then be paralyzed like an ice cube.

Octavia No?

Tannika Saw it on the soap opera.

Daryl If fall in the ice.

Tannika At the North Pole fell in. Then you'd be paralyzed. I did it with my toy.

Nicole I was playing with my friend. We was playing, she ran out the door, fell down the steps, fell to the bottom. When I went down to her, her just lying there. I tried to drag her into the house. Called to the store to get her Grandmother and

Mom. Now she's paralyzed with eyes open.

The previously noted conversation about sleeping with one's eyes open followed the above exchange. There is no clear resolution as to the nature of death. The group keeps trying as in Javar's dream about the fog and Tarzan in session five. Following a poignant conversation about Nicole's mother's death the fluidity of death after a trauma is apparent:

Nicole My mother was in the hospital for a long time
cause of drugs. She has pneumonia many times.

Tannika George Washington died of pneumonia too.

Charles George Washington is on the dollar bill.

Javar On the dollar bill, so he's not dead. He's in
my wallet.

Allisha He's there.

Tannika You're crazy.

This digressed to various children pulling out dollars to show George Washington and thus establish his non-death. The co-leaders made some attempts to clarify the distinction between a picture and the person.

This same session included conversations about the movie Night of the Living Dead and the fine line between coma and death. The group tried to maintain the possibility of life at the point of death. Tannika explained how her aunt had tubes in her mouth and her mother "said she was with the Holy Ghost and the Holy Ghost made her better."

Daryl concluded "If I'm in the hospital and I see the line on the machine go line nnnnnnnn I'll say 'Holy Ghost' and I'd be alive."

The literature review, particularly the work by Thompson, notes the connection between humor and death. Children use humor as a way to express their anxieties and vulnerability on this subject. For the group, the use of humor represents an establishment of distance between themselves and death, a level of mastery they had lost. After a long movie discussion full of examples of people coming back from the dead, where the distinctions between life and death were blurry Charles notes, "You talk about a movie and its scary, then when you see it, it makes you laugh."

Universality of death

The universality of death is the second major element in the latency age appropriate to the understanding of death. However, it is very difficult to isolate this belief within the context of a trauma group. When the children deny the permanence of death they are clinging to the hope that not everyone dies. As the trauma also damages their sense of trust the children expressed the belief that everybody is going to die at any moment, as exhibited in dreams, lack of future sense, and fears about their own lives. By holding both beliefs simultaneously the children exemplify a disturbed understanding of universality. The

issue emerges as a separate entity rarely in the sessions and disappears after session seven.

Religious explanations of death

The children in the group rely heavily on religion to make sense of death. The children introduced God and religion early in the first session. The importance of religion and the acceptance of this subject within the group allowed them to express and develop their theories about God. The group discussed religion in three major forms: expression of anger, religious signs and symbols primarily for healing, and explanations. There is of course overlap here as when God is hated for doing something, the something serving as an explanation for the cause of death. However, as not all explanations included an affect it is possible to delineate those statements which were primarily explanatory.

The two clear anger comments are both directed against God for causing a death. This appears in session one and later in session five taking a very similar form:

Nicole Grandmother tells me he was bad. (the reference is to her dead father whose funeral she did not attend) Now he's with God. I hate you God, you get on my nerves. Why you have to take Nicky....

Javar (retells Nicky's funeral) I went to the funeral, I said to God I hate him why did he have to take her away.

The children in both instances continue the dialogue with no

denials of this thought or follow up remarks about God. The lack of comment in both instances can be linked to the uniformity of belief evident in the group's use of religious explanations. The connection between God, life and death are very close.

This closeness does not necessarily bring about comfort. The group had the idea that one should gain comfort from God in tragedy. However, as the explanations illustrate it is difficult for them to reconcile the ideas of God's power and human suffering. The use of the Bible to ward off evil thoughts and allow sleep was introduced into the group in session one. Prayer is recommended at various points to regain a sense of hope or achieve a closeness with God that will alleviate the pain. When Nicole, in session three, says she wants to die the group provided two death and dangers stories and became increasingly anxious:

Tannika Don't talk about it.

Allisha (cries)

Tannika Pray.

Nicole Prayer don't work, have to protect yourself.

God, you can take your phony act somewhere else.

Javar God works in mysterious ways.

This same back and forth movement around the efficacy of prayer is repeated in session six after Nicole discusses her mother's death:

Octavia You okay Nicole?

Nicole I'm scared now.

Tannika Just pray.

Nicole I said now cause I'm starting to stop saying my prayers. What happens? And she died nothing happens. My Grandmother says if you believe that prayers work, they work.

Tannika I think prayer don't work.

Daryl I used to say my prayers. My great grandmother die. Had a dream about my great grandmother.

Every time I close my eyes I see her.

In both these examples the group maintains the belief that one uses prayer in times of difficulty. The problem rest in the area of results. They hope prayer will prevent the death or pain. The failure of prayer occurs when the suffering is not alleviated and/or the death happens.

Allisha is very clear in this connection in describing her feelings when she learned of her father's death:

Allisha When my father die, me and my mother were at a meeting. My Aunt call, said he had died cause he was in Atlanta Georgia. My mother not believe her, my mother called back and I had to go to bed and say my prayers. I was mad at God, my mother started to cry. Next day had to go to Grandmother's house for the funeral, had a cook out afterwards.

She did not say her prayers because the system had already

failed. God had not kept her father alive.

The religious explanations center on the subject of why children or parents die. Throughout the sessions there is no mention of natural disasters or accidents as the cause of death. As in the case of Allisha's father's death the human cause is not discussed, the focus is on the religious realm.

This religious realm supplies the children with a language to discuss random, senseless death. To some extent the group recites lines as when Tannika says, "At church, they say God gonna come take all the good children, the bad go to the devil." However, two characteristics of their religious language usage point to a deeper meaning than the mere recitation of lines. There is no disagreement with the religious dogma expressed by the group. Even when they question the particular efficacy of prayer the idea that prayer should work is not questioned. Rather, as Javar reminds Nicole in session three, "God works in mysterious ways". The second part of the religious language usage theory stems from the groups' acceptance of religion as a vehicle to explain events. If these were adult lines it is hard to imagine the group would use them in the same fashion as they present horror movies.

There are various attempts to separate God from action in this world and thereby not involve God with issues of human life and death. The following examples from sessions three and five illustrate this distancing technique:

(following a conversation about sleeping with eyes open and two dead fathers)

Nicole Everybody die, but God says everlasting life if believe in me, still be alive.

Allisha That's God's way.

(after Allisha described learning of her father's death)

Daryl When someone dies you can't get mad at God. God don't kill. You born to die.

Allisha My grandmother she preached dust to dust.
(a little further in the same session)

Charles If the people who are dead now come back when we are dead?

Nicole God gonna bring back the angels, we gonna die.

Daryl I ain't gonna have another life.

Allisha Another eternity when we live again.

The final statement on this subject occurs in the last session. There is a resolution offered to the life and death question without severing the power of religion.

(After the first direct reference in the final session to termination and a reminder about the death that began the group)

Nicole They say when people die they be happy, when a baby born you cry cause it has to live in a sinful world.

Charles Should be happy when people are born and hate

it when people die.

Here Charles can assert a life-affirming response 'hate it when people die' without the accompanying fears and anxieties. Death seems solid again and back in its place. The group neither fears for its life nor denies death's universal phenomena.

Distress and Sadness

The literature review places active expression and acceptance of distress and sadness at the final point before reintegration following a death. It is therefore, not surprising to find little evidence for sad affect in the sessions. As the preceding section indicates the group could express anger, denial and confusion without difficulty. However, there are floating expressions of distress sometimes direct and sometimes couched in behavior.

In Allisha's previously delineated discussion of her father's death there is the dilemma about wanting to cry and not crying. Here the anger and fears initially prevented the sadness from emerging. The indirect behavioral manifestations of sadness merging into anger or denial are present when Charles responds to two stories about guns:

Charles It makes me itch.

Co-leader Scary

Charles Take a gun and blow it away.

Tannika Don't talk about it.

Allisha (Crying)

Tannika Pray!

There is no acceptance of the sad feelings, here but rather, a pushing away of the feelings.

The group ends session four with a termination discussion and questions about whether the co-leaders really like them or not. They finish the session all singing 'Leaving on a Jet Plane...'. The song express their sadness and uncertainty about the future.

In the following session Daryl uses a lullaby ('Hush little baby don't say a word...') to soothe himself (and perhaps the group) following a discussion about reasons to kill people and violent horror movies. At the end of this session Tannika, Allisha and Nicole are all crying. Daryl tries to help the crying girls, getting kleenex and taking off Tannika's glasses so she can wipe her face. The group thus expresses sadness through the three girls' tears. It does not resort to anger or denial but provides comfort with kleenex and a suggestion to tell jokes.

The use of jokes as a comfort reappears in the next session.

Charles Why did the chicken cross the road?

Allisha Tell us that joke.

Charles Three jokes, I know how to make them laugh.

Javar Crazy!

Allisha White man said something about a yankee

chinese man say something about.....

.....

Charles I'll tell another joke.

Allisha I know a joke, (tells it) it was funny, why
did the monkey fall out of the tree dead?

Here the jokes do not cover the distress. In acknowledging the need to tell jokes to provide solace for the crying girls the group acknowledges the distress and tries to help.

Termination becomes the locus for sad affect, not so much replacing the trauma, as representing it. This is clear in session seven where both the inability to decide on a topic and the fears about the co-leaders leaving leads to confusion.

Charles Come here to talk about movies, games,
something to make us happy. We could laugh, sad
stuff, everybody's gonna die.

Tannika Don't need to cry everybody get sad gonna cry.

Javar I ask a question, What are we here to talk
about? Her?

Daryl What are we here to talk about, I think we're
here for a party.

Again the desire to feel happy is close to the expression of sadness. However the sadness is right in front now. The acceptance of Allisha's comment in the final session, "I feel sad and lonely," in the midst of a discussion about death and the goodbye party illuminates the movement from the early sessions.

Summary

The children were able to use the group to discuss death in a myriad of angles following the death of a child. The clinical data exemplifies both their abilities to talk about death and their changes in understanding of death. The change in the sessions towards a more age appropriate understanding of death occurred. The relative strength of time and the group process in producing this result is unclear. However, by providing a non-judgmental supportive environment the co-leaders established an arena to allow the children to express their concerns about death.

Chapter Five

Conclusion

It is now possible to return to the hypotheses presented in Chapter One and discover how they stand up to the evidence from the questionnaire and the group sessions.

Hypothesis I: I hypothesized that it is possible to verify the existence of post traumatic stress disorder in children using self reporting questionnaires. If one can confirm the disorder it should be possible to determine any change over time, and differences in answering style due to exposure to the event or gender.

Hypothesis II: I hypothesized that post traumatic stress disorder in children is responsive to group therapy. The children's participation in therapy involves the development of group identity, i.e. group process. The post traumatic stress disorder group process can be explored to show change over time. According to the literature, involvement in a group over time produces heightened group identity and change in the members.

Hypothesis I

There is enough internal validity within the questionnaire to affirm that it tests for post traumatic stress disorder. The three administrations provide information on the course of the disorder over time. There was an overall drop in all symptoms during the test period. Three further points emerge about the individual items on

the questionnaire. The disorder may have various components within it which change at different rates. Those items tapping issues closest to the trauma have the longest effect. The further the psychic difference from the trauma the faster the symptom loses its strength. Secondly, it is clear that children with direct exposure to a trauma report signs of the disorder for a longer period of time. This finding supports all the other data on post traumatic stress disorder where the issue of exposure is explored. The final point concerns gender. Here the effect was quite real but very particular. The stereotypic gender lines are drawn with girls more able to acknowledge and report affect and boys responding with changes in activity (here concentration and school difficulties).

Hypothesis II

This hypothesis is based on the premise that children can do group work. This work includes the formation of a group identity and recovery or a movement towards health. The specific movement for these children involved a lessening of post traumatic symptomatology and a return to age appropriate death concepts (universality and finality). Both the rating scales and the clinical anecdotes produced the necessary information to analyze the group's work. There was change in group relating along the lines the group literature predicted. The children moved towards group concerns and shifted in how they presented information in

their discussion. The children also used the group to report symptoms, try out various remedies and discuss the lessening of fears associated with the disorder. The topic of death occurred frequently and changed in emphasis and content over time.

Various conclusions emerge from examining the material with a questionnaire and rating scales. Most basically post traumatic stress disorder does occur in children. It is possible to use self reporting to both document the existence of the disorder and its course over time. There is a clinical responsibility to this point but, as I will discuss in the implication section, it meets with the most resistance. If we accept children's suffering as real there is then an obligation to act. There is evidence that intervention helps. The lessening of symptomatology from administration one to two may well be due to the class group work during the first administration. The small group sessions hint at the first two meetings as an aid in processing the trauma.

The actual small group work provided the space for the children to explore their fears and anxieties as trauma victims. Their resolution of the trauma is visible in their sense of the future and care for each other. The co-leaders' choice of a psychodynamic group fit the needs of the children to establish a safe environment and regain control over their worries. As a final side note this

thesis demonstrates it is possible to use questionnaires and rating scales and arrive at meaningful information. The change in both the large group of children and the small group emerges out of the statistics of these tools.

Future Research Ideas

In light of the thesis experience there are various things we would do differently. Some of these concern questions I did not know about until the end. Some stem from frustrations set up by the school system. Finally there are issues a little beyond the scope of this thesis that leave interesting, nagging questions. Perhaps if there had been more time or cooperation, these issues could have been explored.

The first type of change centers on the questionnaire. Had there been time, it would have been helpful to use one of the existing post traumatic stress disorder questionnaires modified for this particular population and trauma. In retrospect, consistent use of all nineteen questions on the questionnaire and attempts to return and test absent children would have been useful. The additional questions or use of an already tested scale would provide more support to the results.

If the group sessions had been taped or a non-participatory observer had taken the notes the sessions would probably have yielded more information. Had the leaders of both groups realized the usefulness of the

session notes from the beginning they could have combined note transcripts immediately after each session. This would have preserved more of the flow of the sessions and lessened the amount of lost material.

The school system set up barriers to three sources of further information. They did not allow the group to continue the following school year. They did not allow another test administration. They discouraged any follow up interviews with the children or their families. The school administrators wished to get on with the job of teaching and caring for other problems in the student population. Once they felt enough (if not too much) had been done for these children any further intervention became impossible. It is hard to say if skillful work with the assistant principal or guidance counselors would have resulted in more openness. A better planned liaison with the school probably would have helped the situation.

The 'if only one had the time' list first addresses questions of follow up not allowed by the school. Secondly, this work opens up the question about urban children's pre-precipitating trauma level of functioning. By administering a similar questionnaire to fourth grade children in a different school or a different year one could begin to identify what the normal level of trauma fears inner city children live with on a regular basis. Questions about class, race, socioeconomic levels, geography and age could

be explored by testing a variety of children in different circumstances. The entire study could be replicated over many years in other populations by using the same type of items and methodology behind the group. The comparisons would yield information about the general nature of post traumatic stress disorder and children. This thesis can only hint at generalities; without more knowledge about children's responses it is difficult to say what was particular to this group of children and what is part of the disorder.

The implications of this study stem from the assumption that these children do represent poor urban children's responses to some degree and perhaps children in general. The value of group work, the power of resistance, and the nature of urban trauma are all addressed here. Group work is a powerful force for children. The children's ability to use the group setting to explore their own issues around the accident and develop as a cohesive unit is impressive. These were not children with either therapy experience or familial (or even school) support for intrapsychic work. They worked hard because they needed to reintegrate, we gave them the place to work. They developed an attachment to the group as a separate entity.

The power of resistance emerges when dealing with children's pain. It is hard to hear children's pain. As adults trained to listen we need to give traumatized

children our ears. If we acknowledge this power from the very beginning we can head off its most damaging effects. School systems, administrators, and teachers need support to remain with traumatized children. The tendency to bury the issue or say its all better is very strong. Some of the system work centers on identifying the times when administrators say no or stop treatment. Once these are defined it is easier to help people through their own feelings rather than shutting down the work. This applies to leaders of trauma groups and teachers as well. It is the moment one wishes to stop that one should consider the power of resistance.

The final point concerns urban trauma. All the children in the group had already experienced a traumatic event. They used the group to reorganize and develop coping mechanisms for a society where trauma occurs. We are forced to think about larger questions of reducing the possibility of children experiencing trauma. If there is a societal increase in childhood trauma then we need to develop systems to quickly move in and work with the victims. As the group work exemplifies, the fact that children have experienced a prior trauma does not make them hardened or more able to process a new trauma. Clinical psychologists have the theoretical knowledge and the practical experience to develop programs on both the preventative level and the post-trauma level. It is here the work needs to begin.

Table 1

Intervention Time Frame	
Date	Event
1/29/88	accident
2/3/88	Board of Education Emergency Response Team met with teachers, assistant and principal
2/8/88	St. Luke's team assembled, informed
2/10/88	St. Luke's team plans intervention
2/11/88	St. Luke's team met with teachers, principal administered Questionnaire in small groups with the classes
3rd wk Feb	St. Luke's team reviewed intervention
4th wk Feb	Sent consent letter about groups to school
3/4/88	Assistant principal not hand out letters
3/7/88	St. Luke's team finds no groups; administer Questionnaire
3/21-5/13/88	Small groups meet weekly
1st wk June	St. Luke's team administered Questionnaire; memorial service for child killed in accident

Table 2

Questionnaire Population Breakdown

	Time I			Time II			Time III		
	exp*	unexp*	Tot	exp	unexp	Tot	exp	unexp	Tot
girls	35	23	58	31	21	52	31	25	56
boys	30	23	53	18	14	32	26	20	46
Total	65	46	111	49	35	84	57	45	102

*exposed: witnessed the accident and/or attended the funeral

*unexposed: neither witnessed the accident nor attended the funeral

Table 3
Questionnaire Statistics

Hotelling-Lawley Trace Statistics

Effect	F	DF	Pr>
Time	12.04	(22,294)	.0001
Exposure	2.04	(11,116)	.03
Gender	1.88	(11,116)	.05
Time by Gender	1.17	(22,294)	.3
Time by Exposure	1.57	(22,294)	.05
Exposure by Gender	.56	(11,116)	.86
Time by Gender by Exposure	1.33	(22,294)	.15

Questionnaire Means and R Square by Items

Item	Mean	R Square
1	.75	.64
2	.61	.67
3	.56	.70
4	.47	.68
5	.41	.65
6	.83	.57
7	.57	.57
8	.64	.64
9	.46	.67
11	.35	.68
12	.40	.66

Table 4
Questionnaire Statistics: Items by Time

Item	DF	Mean Square	F value	Pr>F	Level	Mean	St Dev	LSM	Pr>F	
1 think about accident	2,159	4.46	35.57	.0001	T1*	.90	.30	.92	1-2	.07
					T2*	.83	.37	.81	2-3	.0001
					T3*	.51	.50	.51	1-3	.0001
2 obsess on accident	2,159	5.25	36.16	.0001	T1	.82	.39	.86	1-2	.0001
					T2	.62	.49	.61	2-3	.0001
					T3	.37	.49	.35	1-3	.0001
3 feel sad cry	2,159	4.79	34.98	.0001	T1	.77	.43	.78	1-2	.0001
					T2	.61	.49	.54	2-3	.001
					T3	.34	.48	.34	1-3	.0001
4 trouble sleeping	2,159	5.01	33.54	.0001	T1	.71	.46	.71	1-2	.0001
					T2	.39	.49	.38	2-3	.2
					T3	.28	.45	.29	1-3	.0001
5 bad dreams	2,159	4.15	26.40	.0001	T1	.60	.49	.61	1-2	.0002
					T2	.40	.49	.36	2-3	.056
					T3	.21	.41	.23	1-3	.0001
6 worried about own safety	2,159	1.25	11.19	.0001	T1	.92	.27	.92	1-2	.1
					T2	.87	.34	.84	2-3	.01
					T3	.71	.46	.70	1-3	.0001
7 fears about separation	2,159	3.87	19.84	.0001	T1	.66	.48	.65	1-2	.75
					T2	.71	.45	.67	2-3	.0001
					T3	.34	.48	.37	1-3	.0001
8 death thoughts	2,159	1.69	10.79	.0001	T1	.77	.43	.79	1-2	.003
					T2	.64	.48	.59	2-3	.15
					T3	.51	.50	.49	1-3	.0001
9 omens beliefs	2,159	3.02	19.65	.0001	T1	.65	.48	.61	1-2	.0002
					T2	.37	.48	.37	2-3	.9
					T3	.34	.48	.37	1-3	.0001
11 school problems	2,159	4.00	29.06	.0001	T1	.55	.50	.56	1-2	.0001
					T2	.32	.47	.30	2-3	.05
					T3	.16	.37	.17	1-3	.0001
12 lack of enjoyment of activities	2,159	3.05	19.90	.0001	T1	.54	.50	.54	1-2	.04
					T2	.46	.50	.40	2-3	.001
					T3	.21	.41	.18	1-3	.0001

*Time 1: First administration 2/11/88

*Time 2: Second administration 3/7/88

*Time 3: Third administration 6/5/88

Table 5
Questionnaire Item by Time

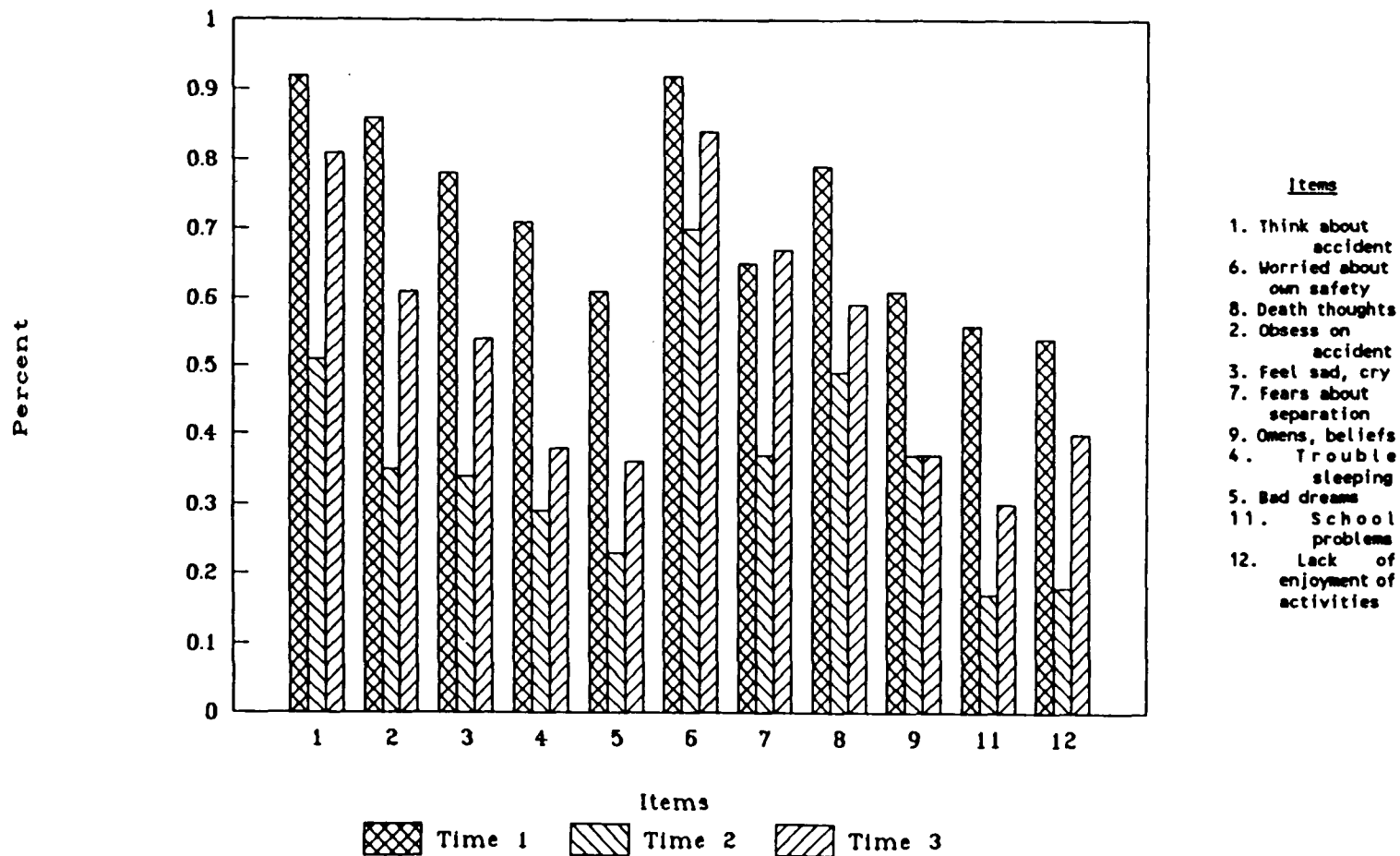


Table 5
Questionnaire Item by Time Graph

Table 6

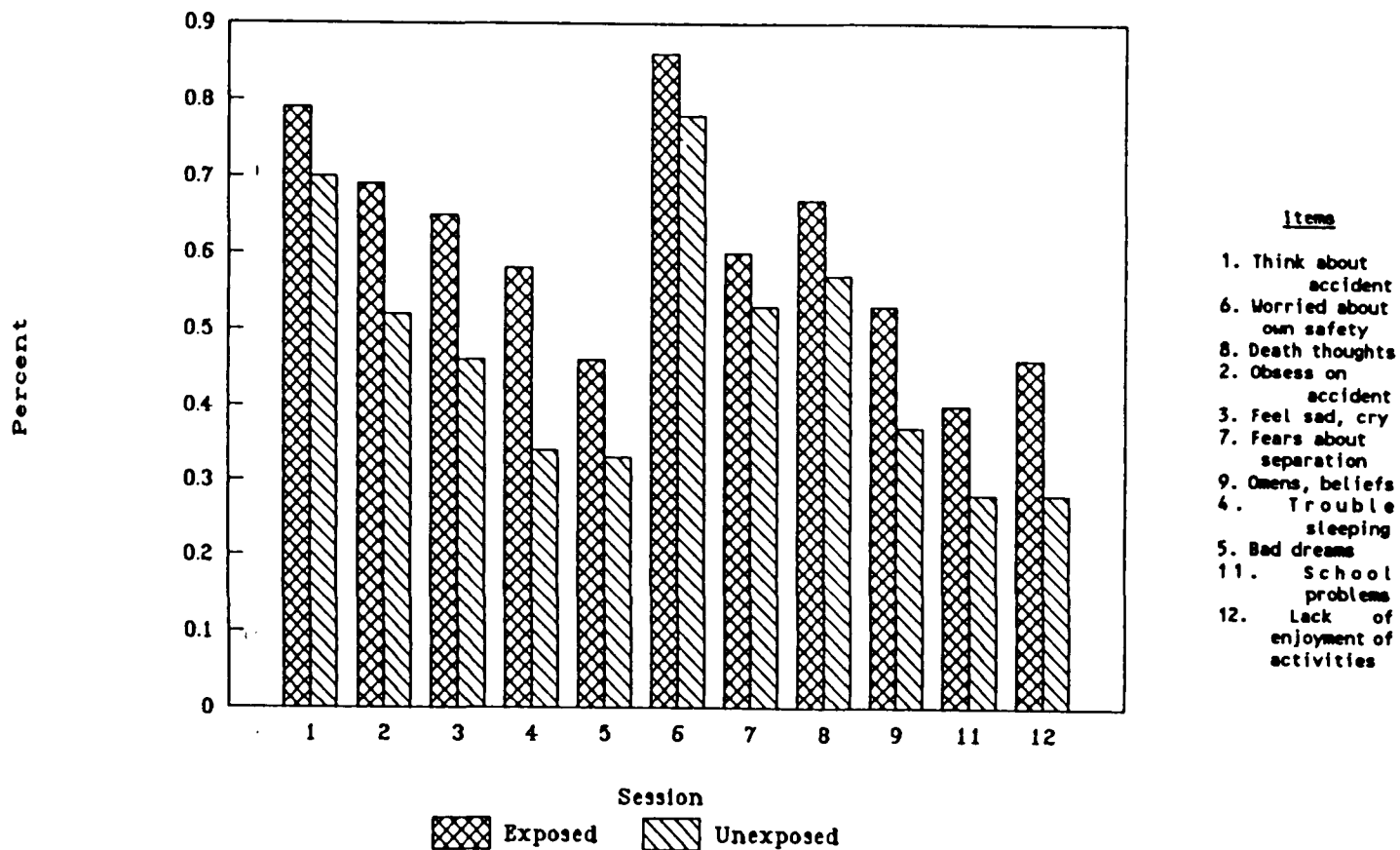
Questionnaire Statistics: Item by Exposure

Item	DF	Mean Square	F value	Pr>F	Level	Mean	St Dev	LSM	Pr>F
1 think about accident	1,126	.71	3.51	.06	exp unexp	.79 .69	.46 .41	.79 .70	.04
2 obsess on accident	1,126	2.62	10.27	.002	exp unexp	.69 .50	.46 .50	.69 .52	.0005
3 feel sad cry	1,126	2.53	9.11	.003	exp unexp	.65 .47	.48 .50	.65 .46	.0002
4 trouble sleeping	1,126	4.38	15.97	.0001	exp unexp	.58 .33	.50 .47	.58 .34	.0001
5 bad dreams	1,126	1.06	3.66	.06	exp unexp	.46 .34	.50 .48	.46 .33	.02
6 worried about own safety	1,126	.64	4.12	.04	exp unexp	.87 .87	.42 .33	.86 .78	.07
7 fears about separation	1,126	.73	2.84	.1	exp unexp	.61 .51	.49 .50	.60 .53	.2
8 death thoughts	1,126	.89	3.04	.08	exp unexp	.69 .58	.50 .50	.67 .57	.07
9 omens beliefs	1,126	2.92	9.26	.003	exp unexp	.55 .35	.50 .48	.53 .37	.0015
11 school problems	1,126	1.15	4.29	.04	exp unexp	.40 .28	.49 .45	.40 .28	.01
12 lack of enjoyment	1,126	2.43	8.10	.005	exp unexp	.48 .30	.50 .46	.46 .28	.0007

*exposed: witnessed the accident and/or attended the funeral

*unexposed: neither witnessed the accident nor attended the funeral

Table 7
Questionnaire Item by Exposure



*exposed: witnessed the accident and/or attended the funeral

*unexposed: neither witnessed the accident nor attended the funeral

Questionnaire Item by Exposure Graph

Table 7

Table 8

Questionnaire Statistics: Item by Gender

Item	DF	Mean Square	F value	Pr>F	Level	Mean	St Dev	LSM	Pr>F
1 think about accident	1,126	.07	.33	.6	girls boys	.73 .76	.44 .43	.74 .75	.8
2 obsess on accident	1,126	.09	.35	.6	girls boys	.63 .59	.49 .49	.63 .58	.31
3 feel sad cry	1,126	.91	3.27	.07	girls boys	.63 .51	.49 .50	.64 .47	.0005
4 trouble sleeping	1,126	.52	1.89	.2	girls boys	.44 .52	.50 .50	.41 .51	.06
5 bad dreams	1,126	.03	.09	.8	girls boys	.40 .42	.49 .50	.39 .40	.8
6 worried about own safety	1,126	.11	.70	.4	girls boys	.85 .81	.36 .39	.85 .79	.2
7 fears about separation	1,126	.05	.20	.7	girls boys	.58 .55	.50 .50	.57 .55	.6
8 death thoughts	1,126	.01	.04	.8	girls boys	.64 .65	.48 .48	.62 .63	.8
9 omens beliefs	1,126	.18	.56	.5	girls boys	.49 .44	.50 .50	.47 .43	.5
11 school problems	1,126	1.75	6.54	.01	girls boys	.28 .44	.45 .50	.27 .41	.004
12 lack of enjoyment of activities	1,126	.10	.32	.6	girls boys	.39 .42	.49 .50	.35 .38	.6

Table 9

Questionnaire Statistics:Item by Time by Exposure

Item	DF	Mean Square	F value	Pr>F	Level	Mean	St Dev	LSM	Pr>F
1 think about accident	2,159	.18	1.41	.25					
2 obsess on accident	2,159	.75	5.18	.007	1unexT1	.83	.38	.87	
					2unexT2	.74	.44	.42	1x2 .0001
					3unexT3	.51	.51	.26	2x5 .0002
					4ex T1	.95	.21	.84	1x3 .0001
					5ex T2	.90	.31	.80	4x5 .0001
					6ex T3	.51	.50	.43	3x6 .0001
3 feel sad cry	2,159	.71	5.21	.006	1unexT1	.76	.43	.80	1x2 .0001
					2unexT2	.43	.50	.41	2x3 .01
					3unexT3	.20	.40	.17	1x3 .0001
					4ex T1	.77	.42	.76	4x6 .0004
					5ex T2	.73	.45	.67	5x6 .04
					6ex T3	.46	.50	.50	2x5 .007
									3x6 .0001
4 trouble sleeping	2,159	.13	.87	.4					
5 bad dreams	2,159	.21	1.31	.27					
6 worried about own safety	2,159	.09	.76	.5					
7 fears about separation	2,159	.29	1.50	.2					
8 death thoughts	2,159	.02	.1	.9					
9 omens beliefs	2,159	.02	.13	.9					
11 school problems	2,159	.17	1.23	.3					
12 lack of enjoyment	2,159	.03	.18	.8					

*exposed: witnessed the accident and/or attended the funeral

*unexposed: neither witnessed the accident nor attended the funeral

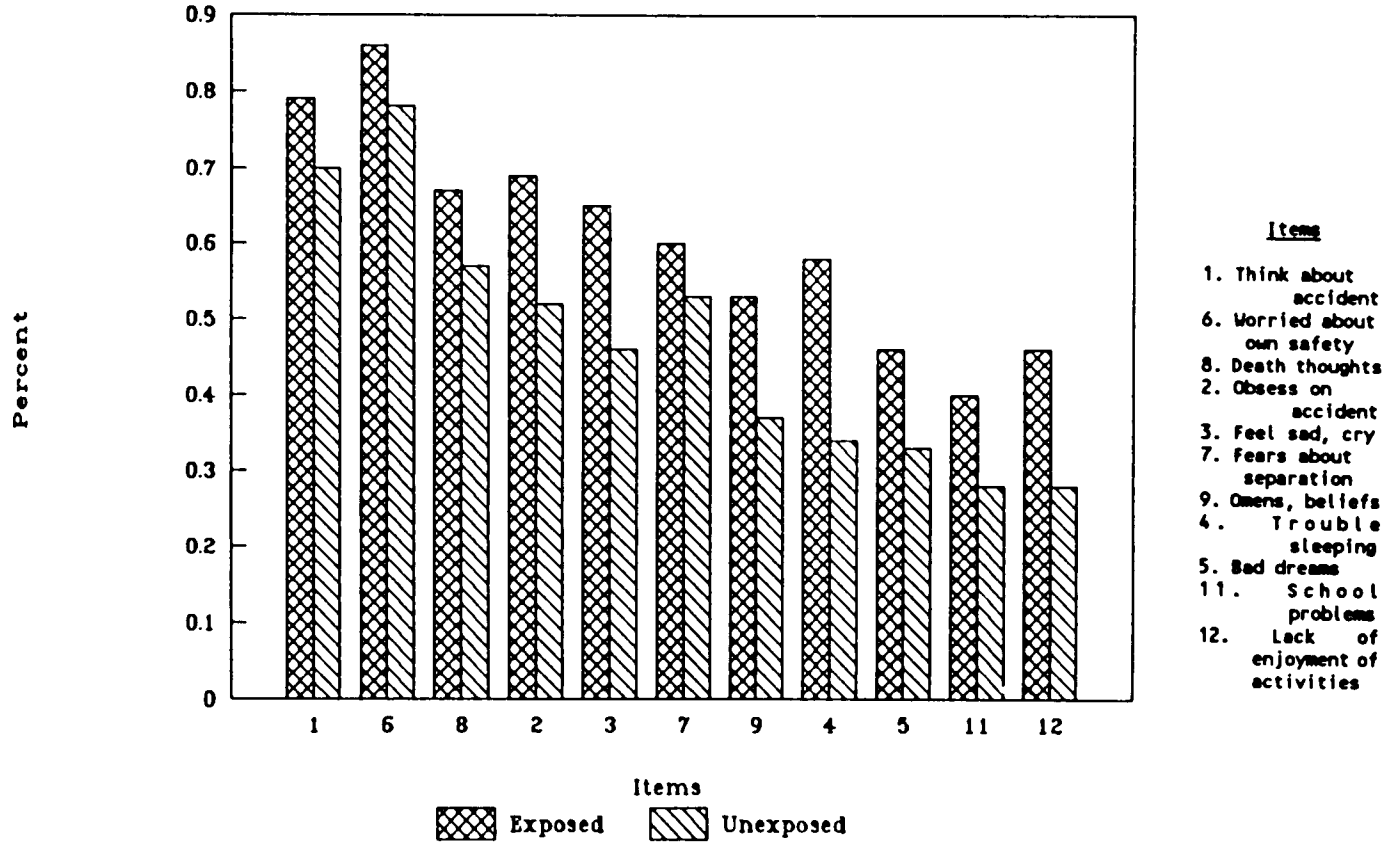
*Time 1: First administration 2/11/88

*Time 2: Second administration 3/7/88

*Time 3: Third administration 6/5/88

Table 10

Exposed/Unexposed % in Pattern Order



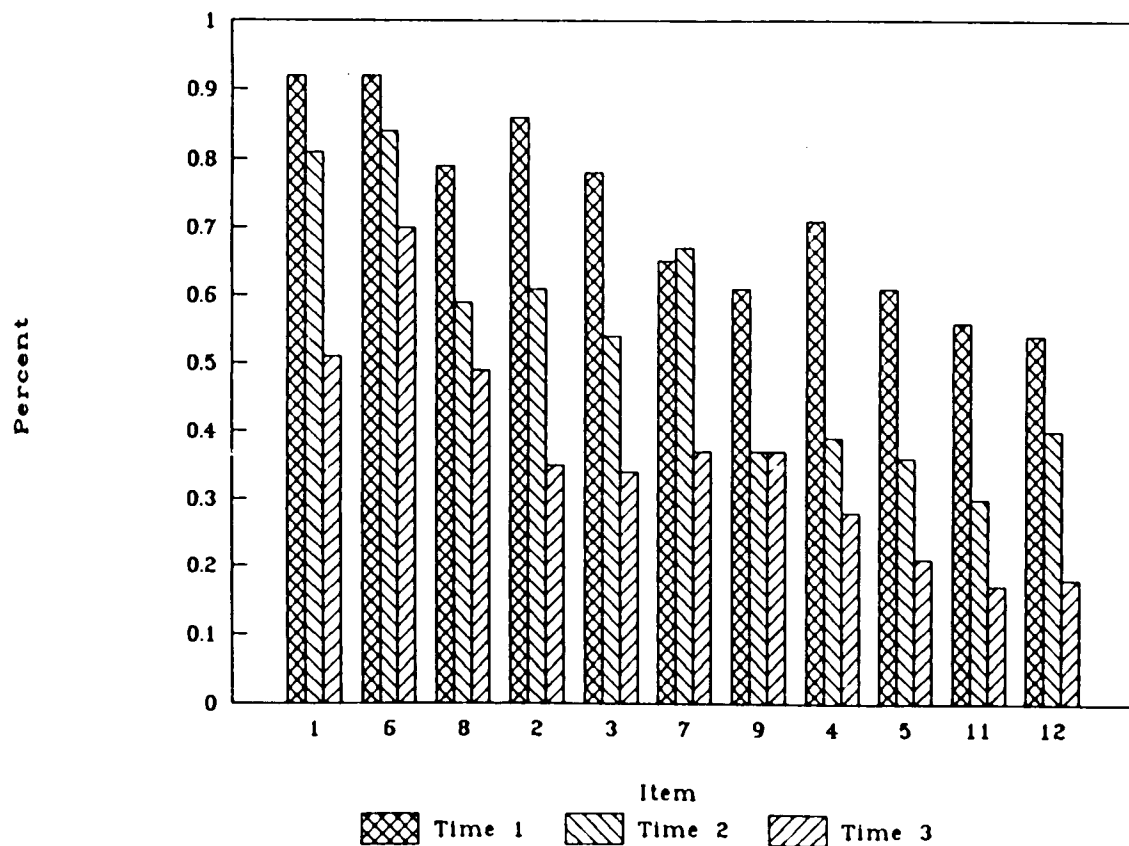
Exposed/Unexposed Patterns Graph

Table 10

*exposed: witnessed the accident and/or attended the funeral

*unexposed: neither witnessed the accident nor attended the funeral

Table 11
Time Percentages in Pattern Order



- Items
1. Think about accident
 6. Worried about own safety
 8. Death thoughts
 2. Obsess on accident
 3. Feel sad, cry
 7. Fears about separation
 9. Omens, beliefs
 4. Trouble sleeping
 5. Bad dreams
 11. School problems
 12. Lack of enjoyment of activities

Time by Exposure Patterns Graph

Table 11

*Time 1: First administration 2/11/88
 *Time 2: Second administration 3/7/88
 *Time 3: Third administration 6/5/88

Table 12

Group Process Definition of Topics: Rating Scale

Accident-direct discussion of accident, child who died, attending funeral.

Personal-family member stories, dreams, eyewitness accounts of events.

Movies/Horror-movies, TV, general horror stories not personally witnessed, newspaper stories.

School-direct comments about school, teachers, classes.

Other-direct comments about each other's behavior, presence or absence in the group or their well being.

Rules-specific instructions, commands to others about how to organize or run the group.

Group-group process comments, feelings about the group results, leaders and termination.

Note the introduction of the above topics as they occur in the sessions.

The continuation of the topic can be shown by the use of questions, encouragement (noises, assent or citing similar experience), and behavioral notes (singing, crying thumb sucking).

Tangential comments are not considered a new topic if the comment is not followed by the other children and the group continues in the original topic.

Table 13

Group Process Introduction of Topics* and Topic + Comments**

Session	1		2		3		4		5		6		7		8		9	
	IT	TC	IT	TC	IT	TC	IT	TC	IT	TC	IT	TC	IT	TC	IT	TC	IT	TC
Topic																		
Accident																		
#	3	9	1	18	1	9	2	14	1	13								
%	25	9	9	22	8	9	8	13	5	13								
Personal																		
#	6	78	5	52	5	69	7	14	6	12	7	70	4	16	5	21		
%	50	82	45	64	38	67	28	13	29	12	35	53	18	15	17	20		
Movies																		
#	1	4	2	2	3	9			4	34	5	23	5	17	2	21		
%	8	4	18	2	23	9			19	35	25	18	23	16	13	22		
School																		
#							4	12					1	3			2	10
%							16	11					5	3			25	18
Other																		
#	2	4			1	6	2	11	2	7	4	30	3	10	4	10	2	6
%	17	4			8	6	8	10	10	7	20	23	14	10	17	10	25	11
Group																		
#			3	9	2	7	7	50	3	19	3	7	8	57	8	36	4	40
%			27	11	15	7	28	45	14	19	15	5	36	53	33	37	50	71
Rules																		
#					1	3	3	9	5	13	1	1	1	4	5	10		
%					8	3	12	8	24	13	5	1	5	4	21	10		
Total																		
#	12	95	11	81	13	103	25	110	21	98	20	131	22	107	24	98	8	56

Accident**& Personal**

#	9	87	6	70	6	78	9	28	7	25	7	70	4	16	4	20
%	75	92	55	86	46	76	36	25	33	26	31	53	18	15	13	20

Group**Related**

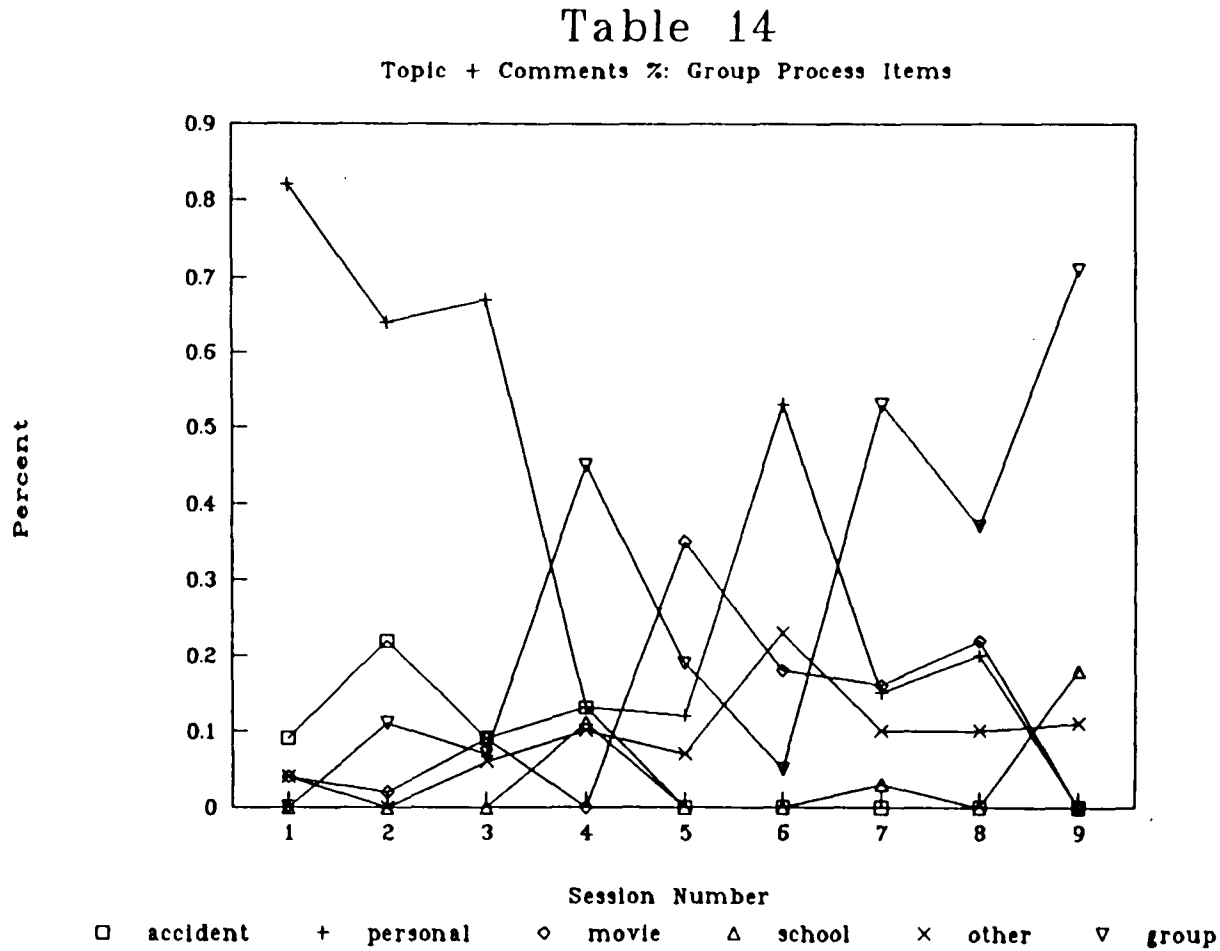
#	3	8	5	11	7	25	16	82	14	73	13	61	18	91	20	78	8	56
%	25	8	45	14	54	24	64	75	67	74	69	47	82	85	87	80		100

slope of -1 for the x y line where group is x and personal is y.

*IT: denotes the beginning of a new topic by one child.

**TC: denotes introduction of topic plus all continuing comments by the group

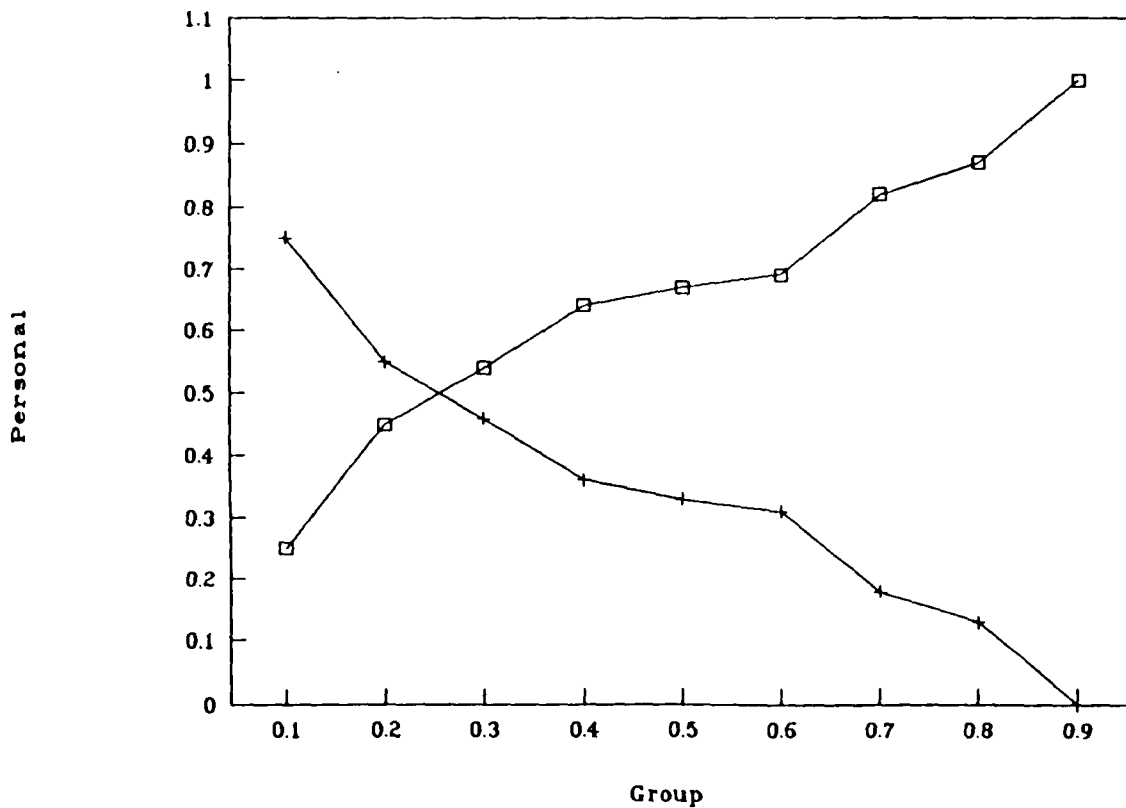
Table 14



*IT: denotes the beginning of a new topic by one child.

**TC: denotes introduction of topic plus all continuing comments by the group

Table 15
Group & Personal Topic % Change Line



+ personal Accident and personal group process items % of total by session

□ group Movie, school, other, rules and group process items % of total by session

Table 15
Group and Personal Topic Percentages Change Line

Group and Personal Topic Percentages By Session

Table 16

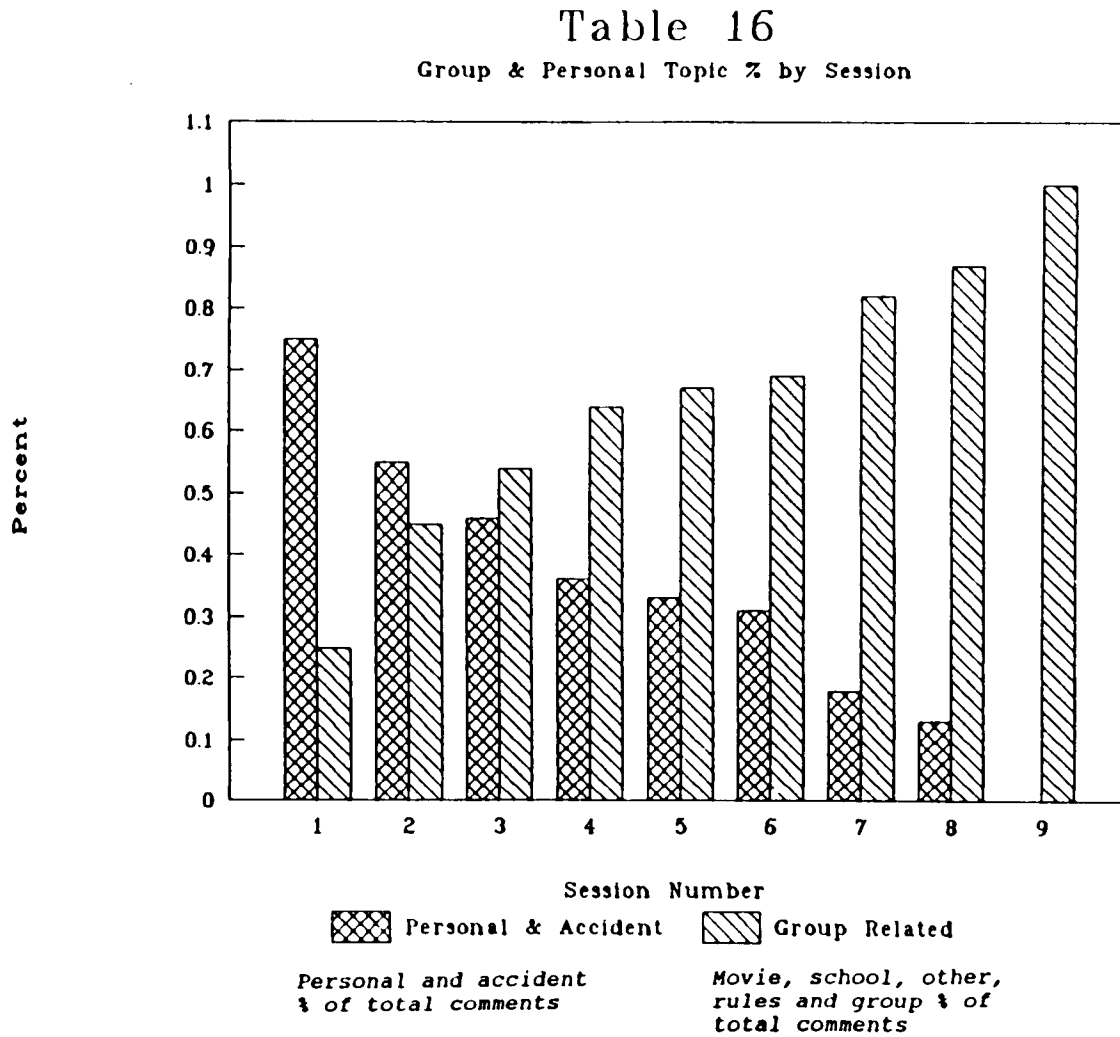


Table 17

Table 17
Group & Personal Topic + Comment %

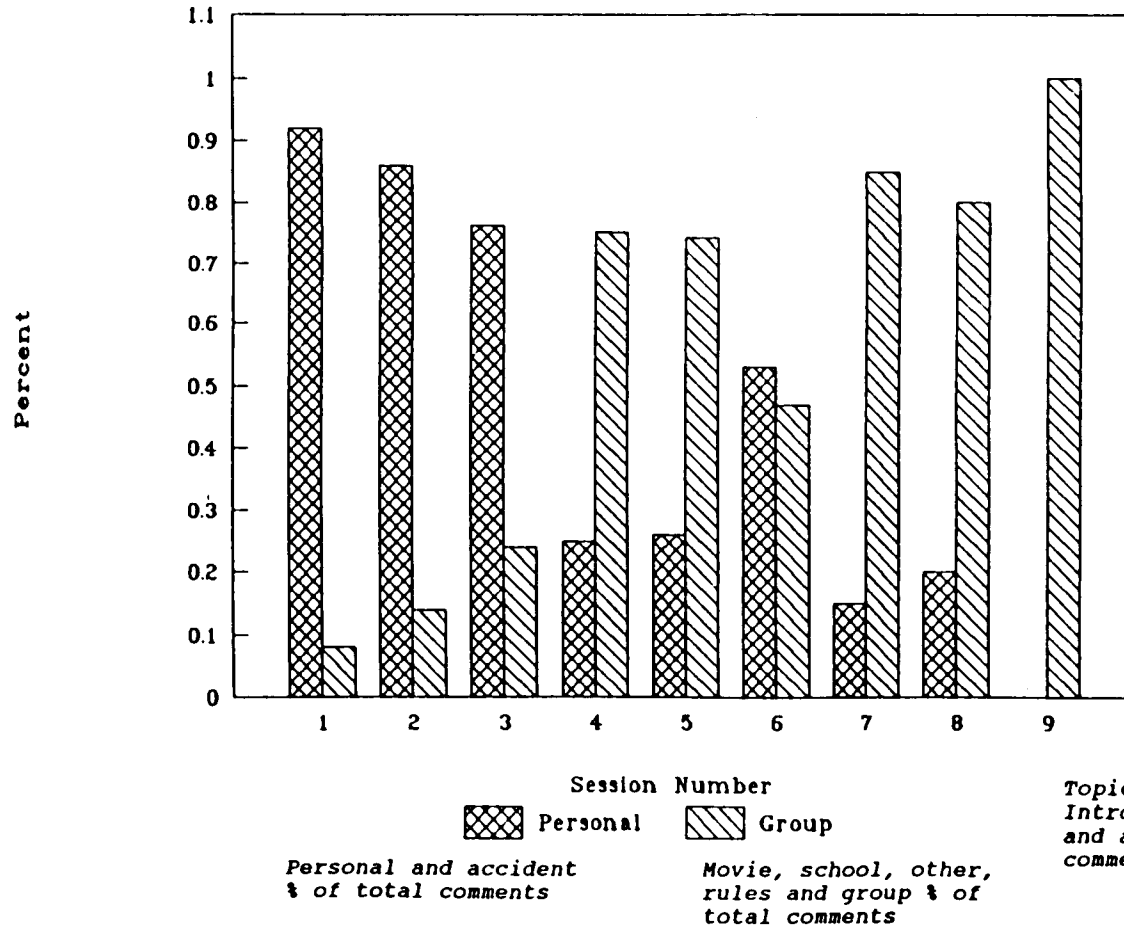


Table 18

Symptom Definitions: Rating Scale

1. fears about own safety- vulnerable, house unsafe, not able to trust others to take care of self.
2. accident/funeral- fears about or comments about these events.
3. dreams- reports of own dreams, fears about having bad dreams.
4. sleep problems- unable to sleep, scared to sleep alone, precautions to insure sleep.
5. school problems- concentration or school work difficulties, discipline problems, difficulties with teachers.
6. family safety- fear of family death/desertion.
7. separation fear- expressed separation worries.
8. spirits- discussion of spirits/ghosts, sighting of ghosts.
9. time sequence issues- problems in time sequences, particularly around the accident.
10. no future- world ending, no vision of future, fears about growing up.
11. omens- prophetic visions or sense of impending doom described about past events.

Table 19

Affirmative Symptom Responses by Session

Item	Session									Tot
	1	2	3	4	5	6	7	8	9	
1. accident	13	1	2	2	3	0	0	0	0	21
2. self fears	6	6	1	0	2	3	0	1	0	19
3. sleep	2	0	9	3	4	0	0	0	0	18
4. dreams	2	6	1	1	3	2	1	1	0	17
5. school	0	0	0	8	0	1	1	0	5	15
6. family fear	5	1	3	0	1	2	0	0	0	12
7. spirits	7	0	1	1	1	1	0	0	0	11
8. separation	3	0	0	1	1	2	1	1	0	9
9. no future	0	4	1	1	0	1	0	0	0	7
10. time seq.	4	0	1	1	0	0	0	0	0	6
11. omens	3	1	0	0	0	1	0	0	0	5
Total	45	19	19	18	15	13	3	3	5	140
Percent of Tot	32	14	14	13	11	9	2	2	4	

Affirmative Symptom Responses by Combined Sessions

Item	1-3	4-6	7-9
1. accident	16	5	0
2. self fears	13	5	1
3. sleep	11	7	0
4. dreams	9	6	2
5. school	0	9	6
6. family fear	9	3	0
7. spirits	8	3	0
8. separation	3	4	2
9. no future	5	2	0
10. time seq.	5	1	0
11. omens	4	1	0
Total	83	46	11

Symptom Responses by Combined Sessions

Table 20

Table 20
Symptom Responses by Time Sequences

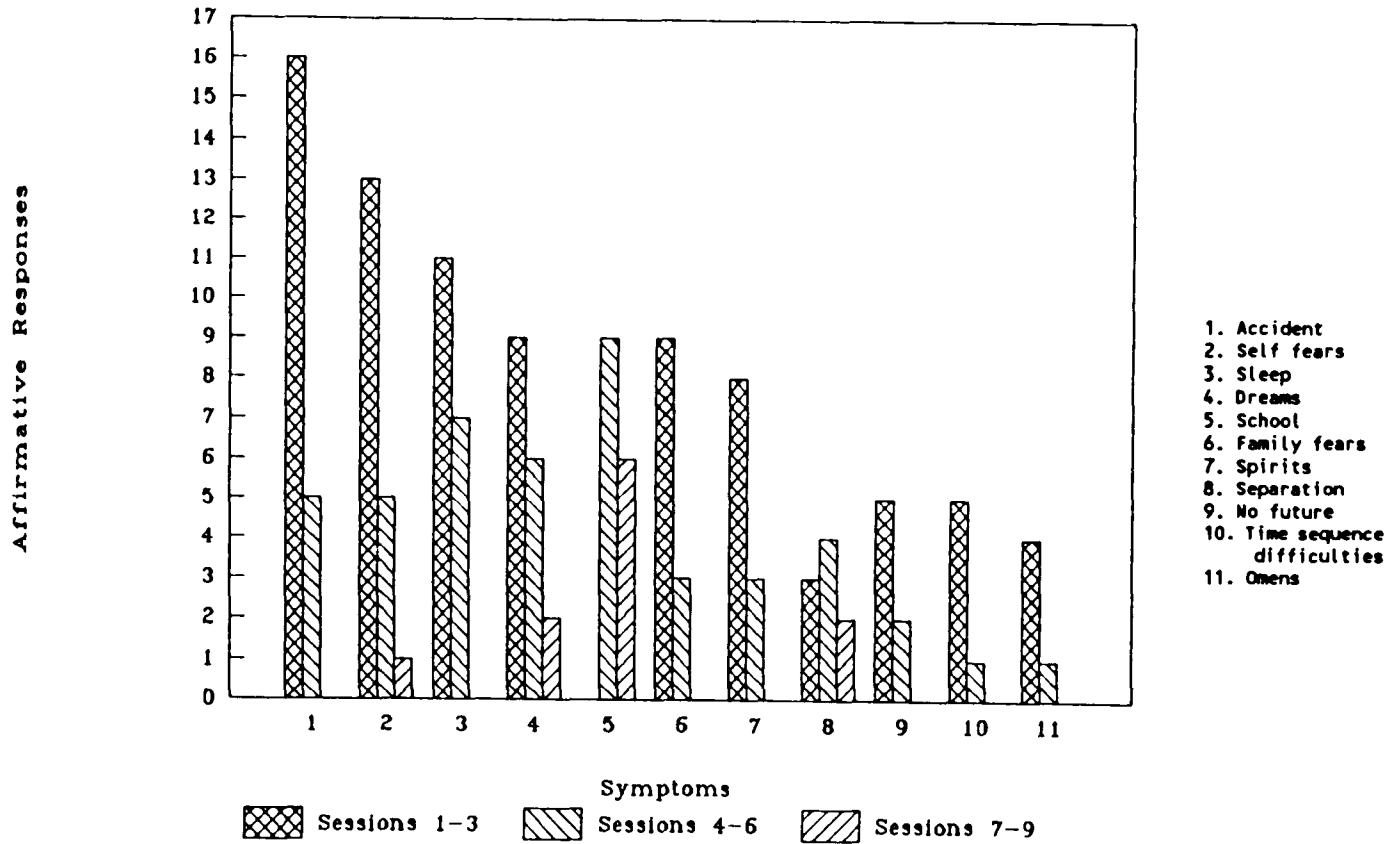


Table 21

Death Comments Definitions: Rating Scale

1. Family death- discussion of family member's death, funeral feelings about and reasons for the death.
2. Other's death- discussion about non-familial death and pet death, both eye witness accounts and second hand reports.
3. Deny permanance- comments that death is reversible, line between death and life very blurred.
4. Anger- expression of anger about death happening and what death means.
5. Distress sad- expression of sad feelings about death, both personal experiences of death and the concept.
6. Religious explanations- direct religious language used to explain how, when and why death occurs.
7. Fear family death- direct statements about fearing family member's imminent death.
8. Fear own death- direct statements about fearing one's own death.
9. Mutilation- discussion about mutilation and death, both personal experience and movies or stories.
10. Universality- comments that death is universal.
11. Suicide- direct statements about own suicidal thoughts or comments about each other's suicidal ideation.

Table 22

Death Comments Rating Scale: Number by Session

Item	Session Numbers									Tot
	1	2	3	4	5	6	7	8	9	
1.family death	3	4	4	0	1	4	2	2	0	20
2.other death	1	0	3	4	2	1	0	2	2	15
3.deny perman	2	0	0	1	1	6	0	0	0	10
4.anger	4	0	1	0	1	2	0	0	0	8
5.distress sad	0	0	0	0	1	3	3	0	1	8
6.relig expl	1	2	2	0	0	2	1	0	0	8
7.fear fam dth	3	0	0	0	2	2	0	0	0	7
8.fear own dth	2	2	0	0	1	1	0	0	0	6
9.mutilation	3	1	1	0	0	0	0	1	0	6
10.universality	2	1	0	0	0	2	1	0	0	6
11.suicide	1	0	2	0	0	2	0	0	0	5
Total	22	10	13	5	9	25	7	5	3	99
Percent of Tot	22	10	13	5	9	25	7	5	3	

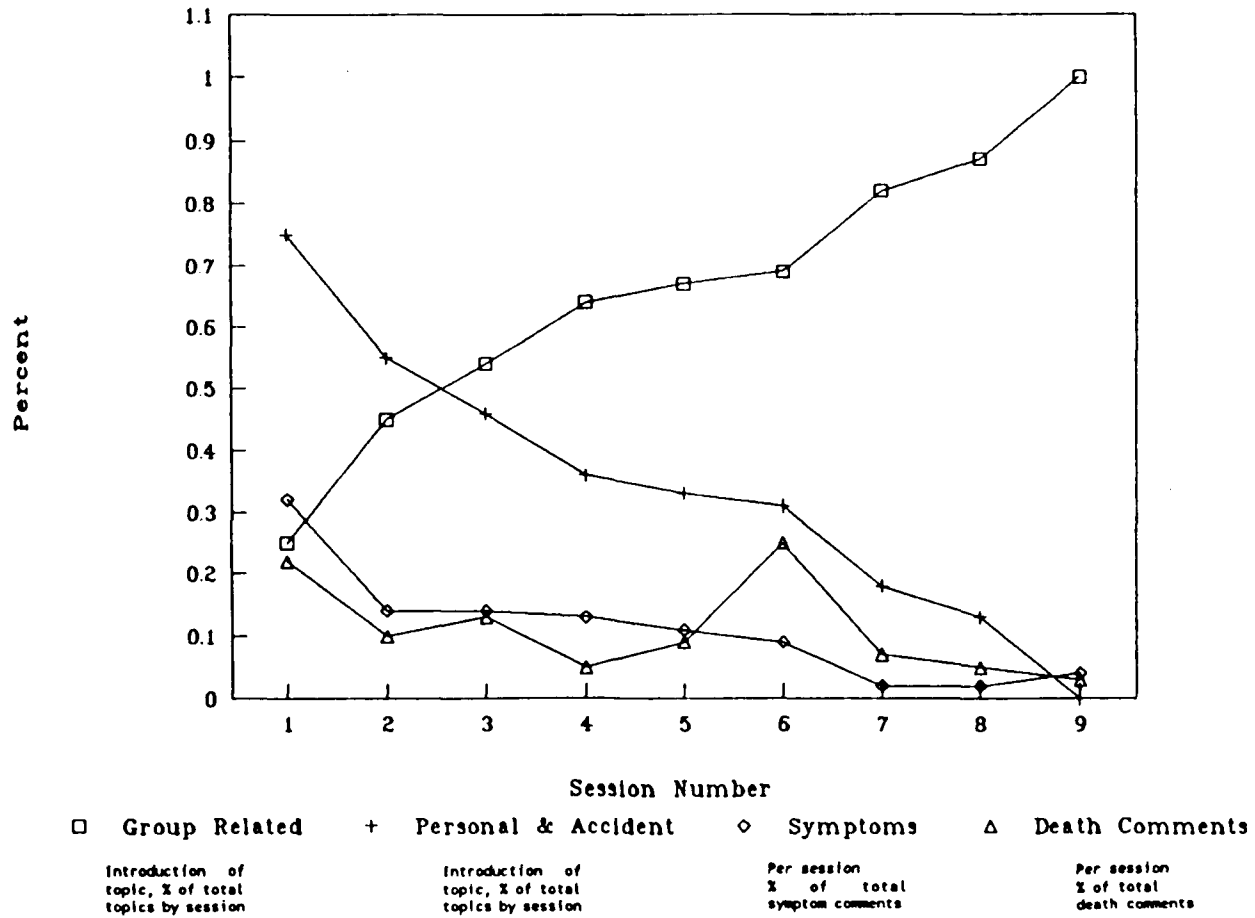
Death Comments by Combined Sessions

Item	1-3	4-5	6	7-9
1.family death	11	1	4	4
2.other death	4	6	1	4
3.deny permn	2	2	6	0
4.anger	5	1	2	0
5.distress sad	0	1	3	4
6.relig expl	5	0	2	1
7.fear fam dth	3	2	2	0
8.fear own dth	4	1	1	0
9.mutilation	5	0	0	1
10.universality	3	0	2	1
11.suicide	3	0	2	0
Total	45	14	25	15
Percent of Total	45	14	25	15

Table 23

Table 23

Group, Topics, Symptoms & Death Scale %



Appendix A
Questionnaire

After a short period of free group discussion the students should be asked to turn over the paper on which they had made their drawing and number it from 1 to 12. Try to cover these 12 items and if time and circumstance allow include the optional items which follow. You may use the asking of these questions as a further opportunity to have the children further elaborate specific recollections and reactions.

Instruction

"I'm going to ask you some true and false questions about how you've been feeling since the accident. Please just put a T if your answer is true and F if it is false."

1. I think a lot about the car accident and the children who were hit by the car.
2. Sometimes I can't get these thoughts out of my head.
3. A lot of times I feel very very sad about it and even sometimes cry when I think about it.
4. Ever since the accident I've had more trouble sleeping at night.

5. Ever since the accident I've had more scary dreams and nightmares.
6. Ever since the accident I've been more worried about being hit by a car or afraid that something terrible might happen to me.
7. Ever since the accident I've been more worried about leaving my family and want to spend more time with them at home.
8. Ever since the accident I've thought a lot more about death and people dying.
9. Before the accident I had a strange feeling that something bad was going to happen.
10. Sometimes I think that the children who got hit were being punished for doing something wrong.
11. Since the accident I've had more trouble concentrating on my school work.
12. Since the accident I don't have as much fun or enjoy things as much as I used to.

Appendix B

DSM-III-R Post Traumatic Stress Disorder

309.89 Post-traumatic Stress Disorder

"The essential feature of this disorder is the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experiences (i.e., outside the range of such common experiences as simple bereavement, chronic illness, business losses, and marital conflict). The stressors producing this syndrome would be markedly distressing to almost anyone, and is usually experienced with intense fears, tension and helplessness. The characteristic symptoms involve reexperiencing the traumatic event, avoidance of stimuli associated with the event or numbing of general responsiveness and increased arousal. The diagnosis is not made if the disturbance lasts less than one month. The most common traumata involve either a serious threat to one's life or physical integrity; a serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence. In some cases the trauma may be learning about a serious threat or harm to a close friend or relative, e.g., that one's child has been kidnapped, tortured or killed...

Age-specific features. Occasionally, a child may be mute or refuse to discuss the trauma, but this should not be confused with inability to remember what occurred. In younger children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters..., or of threats to self or others. Young children do not have the sense of reliving the past; reliving the trauma occurs in action, through repetitive play.

Diminished interest in significant activities and constriction of affect both may be difficult for children to report on themselves, and should be carefully evaluated by reports from parents, teachers, and other observers. A symptom of Post-traumatic Stress Disorder in children may be a marked change in orientation towards the future. This includes the sense of foreshortened future, for example, a child may not expect to have a career or marriage. There may also be 'omen formation,' that is, belief in an ability to prophesy future untoward events.

Children may exhibit various physical symptoms, such as stomachaches and headaches, in addition to the specific symptoms of increased arousal motor action"

Diagnostic criteria for 309.89 Post-traumatic Stress Disorder

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children spouse or other close relatives and friends; sudden destruction on one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:

1. recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
2. recurrent distressing dreams of the event
3. sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative (flashback) episodes, even those that occur upon awakening or when intoxicated)
4. intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma.

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. efforts to avoid thoughts or feelings associated with the trauma
2. efforts to avoid activities or situations that arouse recollections of the trauma
3. inability to recall an important aspect of the trauma (psychogenic amnesia)
4. markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)
5. feeling of detachment or estrangement from others
6. restricted range of affect, e.g., unable to have loving feelings
7. sense of a foreshortened future, e.g., does not expect to have a career, marriage, or children, or a long life

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

1. difficulty falling or staying asleep
2. irritability or outbursts of anger
3. difficulty concentrating

4. hypervigilance
5. exaggerated startle response
6. physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

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