Therapeutic Play Workshops

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Therapeutic Play Workshops for Secondary Trauma

According to Castelloe (2012), "trauma means a violent shock, a wound to the person's self-concept and stability, a sudden loss of control over external and internal reality, with consequences that affect the whole organism." (p.55) Trauma affects more individuals than just the primary victim. Trauma can be passed from one individual to another. When someone is indirectly affected by a traumatic event that is experienced by someone that is close to the individual, it is referred to as secondary traumatic stress. Charles Figley (1983) was one of the first researchers to explore what happens to a family when one individual encounters a traumatic event. A victim and their family impact each other when there is trauma. The family can induce additional stress to the victim, and the family can also detect when the victim has not emotionally recovered from the incident. When the family happens to encounter the same traumatic event together, they can all emotionally support one another (Figley, 1983). Figley concluded that when only one member of the family experiences trauma, all of the family members are affected, and should therefore all be considered victims. The family members who are impacted indirectly tend to become emotionally upset as a result of being empathetic to their loved ones' suffering and tend to take on some of the direct victim's emotions, referred to as "secondary catastrophic stress reactions" (Figley, 1983). This term eventually evolved to secondary traumatic stress, and is relevant to families that have experienced trauma.

Impact on Children of Caretaker's Trauma

Two comparable studies described mechanisms by which the trauma effects are passed on from parents to children. Chrestman (1994) and Danieli (1998) named three mechanisms: parent's silence, identification, and re-enactment. Parent's silence is what happens when the family members avoid talking about what happened to hopefully avoid having the parent's

feelings of aggression emerge which causes the child to fantasize about the actual events and places them in this traumatic world that may or may not be real. Identification is when the child seeks the parent's acceptance and recognition by not talking about the traumatic event. Re-enactment is when the traumatized parent tries to test new perspectives they acquired from the aftermath of the traumatic event.

Researchers have found that there are no differences between traumatized mothers and traumatized fathers when looking at the outcome of the child (Lambert, Holzer, and Hasbun, 2014). The severity of parents' PTSD symptoms negatively correlates with parental functioning and positively correlates with parenting stress, degree of conflict with children, and severity of the parent's discipline on the child (Lambert et al., 2014). Regardless of which parent is affected by PTSD as a result of trauma, there has been much evidence that if a parent has PTSD symptoms, then their parenting abilities will be affected (Lambert et al., 2014).

While Chrestman (1994) and Danieli (1998) came up with four different types of transmissions, Castelloe (2012) discusses two mechanisms by which the transmission of transgenerational historical trauma occurs. One mechanism is primitive identification which "refers to the child's unconscious introjection and assimilation of the damaged parent's self-images through interactions with that parent. This identification leads to a loss of the child's separate sense of self and to an inability to differentiate between the self and the damaged parent" (Castelloe, 2012, p.7). The second mechanism is deposited representation which "is a concept that emphasizes the role of the parent, who unconsciously, and sometimes even consciously, forces aspects of himself on the child. By doing so, the parent affects the child's sense of identity and gives the child certain specific tasks to perform" (Castelloe, 2012, p.7). In

this case the child becomes the receptacle for all the emotions that the parent is not able to work through themselves.

Castelloe (2012) discusses how PTSD has the paradoxical symptoms of arousal and avoidance and how it appeared in the lives of 9/11 firefighters after they returned home when the job was completely finished. The avoidance appeared as social withdrawal and the arousal appeared as irritability. The firefighters repeatedly reported sudden outbursts of rage, both at strangers and at loved ones. This affected the firefighters' parenting abilities because they often described the situation as "taking it out on the kids" or "biting their head off" (Castelloe, 2012, p.65). However, this anger at loved ones causes the patients more distress and sometimes it is the breaking point used to overcome their reluctance to seek treatment for their symptoms (Castelloe, 2012).

Transgenerational trauma. According to the Mohn (2017), transgenerational trauma is defined as a form of trauma that is passed from one generation to the next through genetics and through experiences. This type of trauma is often characterized by the fact that it affects large groups of people who have experienced collective trauma. This collective trauma can then be passed onto the next generation, similar to how a traumatic event to one person would then pass on to their children, except on a bigger scale.

The Holocaust created a massive opportunity to study the effects of trauma on not only the survivors, but also their children and grandchildren. Matz, Vogel, Mattar, and Montenegro (2015) looked at a group of children with parents who survived the Holocaust, and those children reported a sense of expectation by their parents and other family to carry forward the memory of the Holocaust, claiming the memory interferes with their own lives. In conjunction with this finding, Castelloe (2012) observed the children and grandchildren of some Holocaust survivors

and outlined characteristics for the two generations. The first is the unspoken, unmentionable secret which is a great sadness sensed but never expressed. The second is the quest for safety and risk aversion which are messages to stay safe. The third is generalized distrust and insecurity of any state or government. The fourth is the edge of life or death which is when they work in a capacity with victims who are filled with fear and death anxiety because it gives the same life death tension. The fifth is disturbances and disavowal of affect which is when there is severe damage to affect and responses become minimal, inappropriate, or do not exist. The sixth is the paranoid ideation of persecution which means that everyone is an enemy. The seventh is a marked ambivalence toward the person which means that the feelings toward the actual survivor is a mixture of pity and fantasy of repairing the damage. The eighth is ambivalence regarding Jewish identity which conflicts with the wish to avoid potential Holocausts by renouncing Judaism, but also feeling shame and guilt at betraying the parent's cultural identity. The ninth and last characteristic is chronic depression and sadness due to the identification with the familial grief over too many personal losses.

Although intergenerational trauma has been focused on the families who have a history with the Holocaust and its survivors, that is not the only population that generational trauma has affected. A transmission of trauma from one generation to the next, according to Phipps and Degges-White (2014), occurs when a parent's mental issues that are a result of the traumatic experience impair their ability to meet their children's emotional needs. This transmission can be applied to other groups, such as immigrants. Latino immigrants in particular face perceived racial and ethnic discrimination. This can be traumatizing and may create mental health issues when attempting to deal with this discrimination. Traumatic stressors include a negative subjective perception of discrimination, sudden experiences of discrimination, and feeling a lack

of power to stop discrimination (Flores, Tschann, Dimas, Pasch & de Groat, 2010). After examining the results of research Phipps and Degges-White (2014) believe that racial and ethnic discrimination can also produce PTSD symptoms like intrusive thoughts and physiological arousal. The effects of a lineage of trauma can linger long after the immediate trauma is no longer a threat. Combined with the historical trauma embedded in the Latino culture, such as immigration and colonization, and the aversive traumas experienced in the immigration process and in the host country, traumatic experiences are not escaped. Therefore, may be passed down to the Latino youth that grew up in countries like the United States.

Parental PTSD often causes impaired parenting, and later affects the child. Most of the research on this effect has been conducted using self-report, physiological, and observational approaches but none have focused on an inquiry with the people who are experiencing the PTSD themselves. The aim of the study conducted by Sherman, Gress Smith, Straits-Troster, Larsen, & Gewirtz (2016) was to elicit these unstudied first-hand perspectives about veterans' parenting challenges and their perceptions about the impact their PTSD has on their children. In relation to parenting challenges, veterans with PTSD indicated that challenges from three of the four DSM-5 PTSD symptom clusters affected their ability to parent effectively and have a relationship with their child. The clusters of avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity proved to be the biggest problems to work around. There was no indication that intrusion symptoms like flashbacks, memories, or nightmares caused any issues to occur. Avoidance caused difficulties in participating in the veteran's child's activities. Avoidance prevented the veterans from taking the risk of encountering potentially distressing triggers, and the social anxiety prevented them from attending the child's school, athletic, or other extracurricular activities. The veterans reported feeling conflicted with a desire to be

present and support the child but also avoid any possible fear-inducing situations. Veterans facing those symptoms related to negative alterations in cognitions and mood described distorted negative beliefs and expectations about themselves and the world. Many veterans reported feeling unworthy of their children's love because of shame and guilt associated with trauma. This led to, as many veterans described, feelings of alienation from their children and even others in their family. Along with the emotional numbing commonly experienced by veterans, they also experienced a desire to love and feel connected to their children, but had trouble feeling any emotional attachment (Sherman et al., 2016).

The last thing veterans described as causing difficulty in parenting were the PTSD symptoms associated with alterations in arousal and reactivity. The hypervigilance and exaggerated startle experience create an over awareness of the surroundings and then stress increases. With these symptoms, irritability and aggressive behavior also play a role in veteran's actions towards their children. In effect, veterans suggested that their military training along with PTSD led them to have several incidents involving aggressive urges, threats, or actual violence toward their children (Sherman et al., 2016).

Sherman et al. (2016) also looked at how veterans perceived their effect on their children because of their PTSD. Veterans indicated that their children experience sadness, hurt, anxiety, and confusion in response to a specific parental behavior or more generally struggle with painful emotions and moods. Other emotional reactions that veterans perceived their children to have are frustration and resentment toward the parent, fear of the parent, and self-blame for the parent's behavior. The veterans think that their children's resentment comes out of the fact that they are disappointed and angry with the parent for not spending enough time with them or because they feel that the parent is faking to get attention. Veterans also believe that the children fear when

they display anger and aggression or high levels of a need for control. Veterans also find that their children blame themselves for their parent's mental health symptoms, often wondering what they as the child have done wrong to upset their parent.

Veterans not only recorded their child's emotional reactions to their PTSD symptoms but also their behavioral reactions (Sherman et al., 2016). The study found that some children reflected distress because they withdrew physically from the parent or family by isolating themselves in their bedroom. Other children pretended that the PTSD- affected parent no longer existed by not including them in the family or other extracurricular activities. Some children were even described as imitating the parents PTSD symptoms like being hyper-vigilant and talking to others disrespectfully.

In contrast, children also provided the veteran with emotional and possibly instrumental support. As Figley (1983) mentioned, family members can impact each other when trauma arises. In conjunction with this, Sherman et al. (2016) noted that children were found to help ground veterans when they were re-experiencing symptoms, load doctor appointments in a calendar, remind parents to take their medications, express love during difficult times, and not only acknowledge the parents triggers but also attempt to help minimize the parents exposure to them. The children understood their parents needed help, and did what they could to help their parents deal with the aftermath of trauma.

While Sherman et al. (2016) looked at the veteran's perception of the child, Lambert et al. (2014) looked at whether or not a parent's report was accurate. Lambert et al. (2014) found that parents with elevated PTSD symptoms tend to evaluate their children as more distressed than the children rate themselves, making a parent's own report not as accurate as a clinician's evaluation of the child.

Parent's mental health. Trauma is a conduit for mental illness. When looking at individuals suffering from PTSD, approximately 88.3 percent of women and 79 percent of men have at least one other disorder present as well (Lombardo and Motta, 2008). Looking at the relationship between trauma, mental illness, and PTSD combined, Lombardo and Motta (2008) concluded that from past secondary trauma research, it is likely that family members, children specifically, are impacted by an individual that has experienced first-hand trauma. When PTSD is combined with another mental illness, whether that illness was there before the trauma or not, the symptoms of other mental illnesses can be enhanced, causing further traumatization of the child or parent (2008).

Lombardo and Motta (2008) conducted a study to explore if children of parents that had both PTSD and a mental illness were more likely that children of parents with a mental illness, other than PTSD, to develop secondary traumatic stress. In this study there were three groups, one group with parents having both PTSD and another mental illness, the second group having parents that only had a non-PTSD mental illness, and the third group of parents without any mental illness. Using self-report data from parents, followed by a clinical visit, Lombardo and Molta (2008) found that children of parents that had both PTSD and an additional mental illness are more likely to experience secondary trauma in comparison to parents that only had a mental illness.

The second hypothesis that children of parents with only mental illness would be more likely to develop secondary traumatic stress in comparison to children of non-ill parents was also supported. Mellor, Davidson, and Mellor (2001) confirmed using three groups, Veteran with PTSD, Veteran without PTSD, and civilian, that veterans with PTSD were less well-adjusted than the other two groups on measures of self-esteem, stress symptomatology and family

functioning. In comparison, there were no differences found between the other two groups. This finding could be similar with non-military parents with trauma history because, although they are not veterans, it does not mean that they are not impacted in a way that is similar to Veterans with PTSD. Depending on their type of trauma non-military parents could suffer similarly to that of a Veteran with PTSD.

Family dynamics and parent child relationships affected by trauma. Trauma not only affects individuals but also the family dynamic. Mellor et al. (2001) hypothesized that there would be significant differences between the children of veterans with PTSD compared to children of civilians and Vietnam veterans without PTSD in regards to lower self-esteem, increased stress symptomatology, and poorer family functioning. The conclusions that were reached only supported this partially, as no significant difference was found on the measures of posttraumatic stress symptomatology or self-esteem. This finding indicates there were no significant differences in children in the three groups of populations. However, the aspect of the overall measure of global functioning were found to support the hypothesis. PTSD veteran children rated their families' global functioning to be dysfunctional and significantly worse than the non-PTSD veteran children who viewed their global functioning as borderline. Both of these groups' ratings are significantly worse than the ratings of the civilian children who rated their families as functioning normally. This is significant because it reveals that the veteran's children are rating their families as performing worse in a variety of health and mental health environments compared to civilian children.

When looking at a two-parent household where one of the spouses has experienced trauma, it is also important to look at the spouse who was not directly affected by a traumatic experience. When examining combat exposed individuals who have experienced PTSD, it is

important to note that the individual's children and spouse are also at risk for developing secondary stress (Herzog, Everson, and Whitworth, 2011). Herzog et al. (2011) asked three specific questions to determine if there was an influence present from having a family member who had specifically endured a traumatic experience. These questions addressed whether the soldier experienced increased levels of traumatic stress symptoms, if the spouse's secondary traumatic stress correlated with the primary traumatic stress symptoms of their spouses, and whether secondary spousal stress symptoms mediate the secondary stress that existed within the couples shared children (Herzog et al., 2011). After issuing a one time survey to soldiers and their spouses, Herzog et al. (2011) determined that over half of the soldiers had a clinical level of self-reported traumatic stress, and 14 percent of the soldiers' spouses were in the clinical range as well. The spouse's secondary trauma appeared to add to the child's secondary stress, when combined with the soldier's PTSD symptoms. While one parent being traumatized can impact a child, this study noticed that when the traumatized parent caused his or her spouse to have secondary trauma, the child would have secondary stress as a result from both parents being exposed to trauma; directly or indirectly (Herzog et al., 2011).

While secondary stress is a concern for the spouses of individuals who have PTSD, another concern is the effect of PTSD on the relationship. Costelloe (2012) looked at the erratic behavior caused by PTSD and how that influences the spouse. In the study, Costelloe (2012) looked at the firefighters who were involved in 9/11, and how their behaviors after the event became intolerable for many of the spouses. Many of the spouses presented with depression or withdrew psychologically from their partners. As a way to cope with PTSD, some firefighters reacted by having affairs in an attempt to counteract their own distress or to cope with their

spouses inability to understand. This behavior often led to divorce or cohabitation without a relationship between the spouses (Costelloe, 2012).

When a parent is diagnosed with PTSD, poor relationships between child and parent are reported more often. In a study conducted by Van Ee, Kleber, and Mooren (2012), emotional availability of the mother was observed when the mother experienced trauma and the child did not. Emotional availability contributes to the parent's relationship with their children. It was found that there was an association between the mother's PTSD symptoms, and her report of the infant's psychosocial functioning. Psychosocial functioning refers to one's ability to function in a social situation. In the study, mothers with PTSD symptoms were more likely to report that their infants had poor behavior, which would in turn lead to the mother having negative mental representations of the child. Van Ee et al. (2012) concluded that mothers with these symptoms had less emotional availability for their child when parenting, and infants of traumatized mothers may have impaired psychosocial functioning later in life, in comparison to a child with a non-affected mother (Van Ee, Kleber, and Mooren, 2012). Due to the mother's having the perceived thought that the child had psychosocial functioning issues, it was thought the mother would then have a negative outlook on her child because the mother would see that as a negative feature, which would in turn cause their relationship to be weaker. The study stated that any infant who experiences unavailable parenting is at risk of having negative adaptations, regardless of if their parent has PTSD.

Effects of Secondary Trauma on the Child

While there are multiple issues that are apparent in the parents who experience trauma their children also display issues. Lester, et al. (2010) suggested that active duty parent PTSD symptoms predict child depression, along with internalizing and externalizing behaviors. The

authors also found a significant association between severity of military parents' PTSD and their preschool-aged children's separation anxiety, along with increased emotional and behavioral problems among their school-aged children. A review of literature done by Creech and Misca (2017) found a consensus that parental PTSD symptoms have an effect on a child's internalizing and externalizing symptoms, including depression, social emotional adjustment for young children, increased anxiety in early childhood, and adjustment problems for those children of school-age. Lambert et al. (2014) concluded that overall the research suggests that parents' symptoms of PTSD are associated with their children's poor psychological well-being. Going even further, the parents' PTSD symptoms positively correlate with children's anxiety, depression, PTSD, and behavioral problems. This research demonstrates how the trauma of the parents becomes secondary trauma as their children are affected in a variety of ways. This research points to the significant impact that the parental issues with PTSD and trauma have on their children, even to the point of in some cases using the parent's trauma symptoms to predict the child's behavior.

Biological effects. One of the effects of secondary trauma is biological. Thomson (2015) looked at how transgenerational trauma is passed through genetics. Studying survivors of the Holocaust and their children, Thomson (2015) found an epigenetic change in the Holocaust survivor's genes related to stress. A chemical marker on the stress gene was changed because of the traumatic experience the survivor went through. The same change on the stress gene was found in the survivor's children, even though the children themselves did not experience the trauma. In conclusion, these changes in stress genes can be passed to future generations through genetics and is support for the notion of secondary trauma.

Besides genes there are other biological relations to secondary trauma. Yehuda et al. (2005) concluded that transgenerational trauma can be caused by biological factors such as cortisol levels. A reduced cortisol level in adults with PTSD was concluded to be a significant factor that influenced the transmission of trauma effects. A lower than normal cortisol level compromises the stress response that serves as a protective factor against PTSD. Higher than normal cortisol levels place a person in a state of constant hyper-stress from which it is difficult to relax. In the case of children who experience transgenerational trauma, it matters whether or not the child was in their mother's womb at the time of the trauma. Phipps and Degges-White (2014) found that the women who experience trauma before or during pregnancy and have been diagnosed with PTSD have low cortisol levels on their own. When their babies are born, those babies had low cortisol levels as well, which leaves the infants vulnerable to anxiety and stress due to a their now compromised stress response system (Phipps and Degges-White, 2014).

Psychological effects. Along with biological effects there are also psychological effects. A study done in 1985 by Rosenheck and Nathan found that children of war veterans suffering from PTSD suffered from insomnia, psychosomatic symptoms, anxiety with nightmares and near death experiences. The children displayed symptoms of other issues like short attention span, concentration problems, helplessness and learning disabilities. Another study done in 1991 by Harkness had similar findings in that the children of veterans suffered from depression and anxiety with schizoid personality traits, that they had a non-communicative style of interaction, were aggressive and hyperactive, and had more psychosomatic symptoms than did the other children with parents who did not have trauma. Daud, Skoglund, and Rydelius (2003) found statistically significant differences between the children with traumatized parents and the children without traumatized parents in respect to the diagnoses of behavioral disturbances,

adjustment problems with signs of depression, PTSD, anxiety, somatization, and psychosocial stress factors. These findings indicate that children who have parents with a trauma history suffer from psychological effects ranging from depression, anxiety and insomnia to schizoid personality traits, psychosomatic symptoms and learning disabilities.

In addition to these findings, Daud et al. (2003) found that in a torture traumatized parent group, 93 percent of the parents fulfilled the criteria for PTSD, anxiety syndrome, and somatization. Many of these parents' children also exhibited PTSD symptoms; 38 percent of the boys and 71 percent of the girls displayed PTSD symptoms like their parents. Also, 69 percent of the boys and 71 percent of the girls displayed symptoms of the anxiety. Finally, 46 percent of the boys and 43 percent of the girls displayed signs of somatization. Daud et al. (2003) hypothesized that children of traumatized parents who experienced torture, display symptoms of psychopathological disorder in significant greater amounts than those children with non-traumatized parents from similar ethnic and cultural backgrounds. The research findings confirmed that children from families where at least one parent experienced torture of some kind exhibited psychopathological symptoms, like depressive symptoms, post-traumatic stress symptoms, somatization and behavioral disorders more often children from families where neither parent has experienced some kind of torture.

Children may exhibit impaired behaviors that develop from a distress response to secondary trauma. Some examples of impaired behaviors include antisocial behaviors, acting out, depression, and anxiety, or in some cases a combination of depression and anxiety, as well as internalizing his or her problems, rather than talk about them with another person. These are common effects when a child does suffer from trauma (Herzog et al., 2011; Hilarski, 2004). Internalizing problems is the term that Herzog et al. (2011) uses to describe when an individual

has negative behaviors focused inward, and these behaviors tend to mostly affect the individual directly, rather than affecting others. Herzog et al. (2011) examined the impact of a soldier's stress on the family, and yielded some strong conclusions. There was a correlation noticed in the one-time survey that indicated that soldiers determined that their children were internalizing their problems, rather than externalizing them. The spouses of the soldier also saw children internalizing their problems. When looking at these children's levels of secondary stress, two of the children in the study were reported to being in the clinical range, and another child was on the border of being deemed clinical for total secondary stress levels. Internalizing problems were a key symptom group found in children experiencing secondary stress (Herzog et al., 2011).

Lombardo and Motta (2008) looked specifically at depression and anxiety rates of children with parents that had a mental illness, and had contributed to secondary trauma in the child. Secondary trauma was higher among children whose parents had a mental illness, as opposed to parents with no illness, or parents with mental illness and PTSD. However, children of parents with both PTSD and a different mental illness had the highest levels of anxiety and depression. In the study, participants were observed clinically, and self-reported their symptoms. When secondary trauma was present in the children of the study, a positive correlation with anxiety and depression was noted both by the clinician reporting, and was self-reported by participants.

Lambert et al. (2014) had a similar goal to determine if there was an association between parent PTSD and the child’s tendency to have PTSD symptoms, anxiety, depression, general distress, or behavioral issues. This study had two focuses however. One group in the study observed the outcome of the children when only the parent had experienced trauma, and the other group observed the outcome of children where the child also experienced the trauma

directly. When the child directly experienced the trauma as well, the risk factor for behavioral issues was higher. Another factor this study noted was that it did not matter which parent had experienced the trauma; traumatized fathers were as likely to affect their children as traumatized mothers. Lambert et al. (2014) did mention there was a limitation present of participant availability and participant self-evaluation.

Children's coping techniques. When children experience a stressor, the children will oftentimes find a way to cope. When looking at trauma, directly or indirectly, the children will often find a way to deal with his or her environment. One form of trauma that was observed by Evans and Kim (2013) was poverty. While the parent in the situation would have to deal with the economic and emotional hardships of surviving in poverty, the child is also coexisting in the environment and will be affected by their living in the environment and the parents' response to the environment. Avoidance and withdrawal are two forms of coping that will later lead to negative effects on the children. One of the reasons for why the children choose these methods of coping could be because the parent is consumed with handling the stressor in his or her own way, and has impaired parenting abilities because of the situation (Evans and Kim, 2013).

Stress reactions occur when the child is experiencing secondary traumatic stress. When a child is witnessing the behaviors of their parents that come from the parent being traumatized, intense worry is a reaction that can occur (Lombardo and Motta, 2008). The children may worry that he or she will end up behaving like their parent in the long run (Lombardo and Motta, 2008). Stress reactions are considered to be a form of coping, which includes involuntary engagement and secondary control coping, according to Lombardo and Motta (2008). Involuntary engagement includes intrusive thoughts, emotional and physiological arousal, and impulsive actions, while secondary control coping is when the child adapts to the environment. The way

the children cope impacted the severity of their secondary trauma responses. When a child adapted to the environment, rather than having involuntary engagement, his or her symptoms of anxiety, depression, or aggression were less severe (Lombardo and Motta, 2008).

Substance abuse in children who have experienced secondary trauma is often a means of self-soothing. Studies have suggested that the reason behind choosing alcohol as a way to self-sooth is because it can sometimes mask the feelings of anxiety (Hilarski, 2004). While not too many studies have examined the direct correlation between secondary trauma and alcohol abuse, Hilarski (2004) determined that secondary trauma and alcohol abuse do appear to be correlated. In addition to use of alcohol and secondary trauma, Hilarski (2004) noted that anxiety levels were also present in the children. Klanecky, Woolman, and Becker (2014) focused on the connection between sexual abuse and alcohol use. The study used a Drinking Refusal Self-Efficacy questionnaire and asked participants to describe how easily they can refuse alcoholic beverages. The participants in the study also self-determined if they had any PTSD symptoms. Based on participants' answers, the researchers concluded that a positive correlation exists between trauma exposure and drink consumption. One area of this study that is important to note is that participants were responsible for judging their own behaviors, rather than being clinically assessed, which can be inaccurate. Self-assessments can be biased and a clinical assessment is more objective. Another important fact of this study was it observed direct trauma rather than secondary trauma, and impact on one's likeness to turn to alcohol. Secondary and direct trauma lead to similar risks however, so there is probability that those suffering from secondary trauma are also likely to turn to substance abuse.

Programs and Interventions for Children Suffering from Secondary Trauma

Benefits of play. Many people as children participate with their friends in make-believe games. While children see play as something that is fun, researchers have observed the benefits that play produces. Howard (2010) determined that play is one area that can impact a child's ability to meet challenge because the act of play creates a low-risk environment where children can explore skills that may lead to developing his or her emotional and intellectual intelligence. Sutton-Smith (2003) looks at play as a way for children to experience situations and emotions that are not experienced throughout every day of their lives such as an emotion a child would not likely encounter similar to grief. During an imaginary situation, children have the freedom to experience these emotions without losing control. Children have the ability to regulate the emotions of attention, arousal, and acting out while in the context of play.

It has also been noted that play can help children face difficult factors in their lives. Rutter (1985) stated that children can cope with a few adverse factors, but too much adversity can cause stress. To reduce stress, children must be flexible and adaptable; two qualities that come through play (Rutter, 1985). Play can also impact the cognitive and affective processes that are important for development. During play, children can develop cognitive skills that will help them throughout their lives. Some of these skills include generating ideas, solving problems, using symbolism, and recognizing cause and effect (Fiorelli and Russ, 2012). The cognitive process that is used in play can create divergent thinking in children, which is the ability to generate multiple solutions for a problem, which is a key skill for children to have (Fiorelli and Russ, 2012). All of these skills combined provide the child with tools that will help him or her in all aspects of life, from problem solving to developing relationships.

Play as a coping strategy. Fiorelli and Russ (2012) noted that children who use more imagination in their play tend to succeed more frequently at solving problems and cope more

effectively than children who do not. It is believed that the children that express more emotion tend to be better adjusted, cope more effectively, and are more creative (Fiorelli and Russ, 2012). The children in the study were observed while playing, and those that used more imagination were reported to have more positive experiences each day. When looking at the same group of children eighteen months later, the children who had more imagination in their play demonstrated greater coping mechanisms. In the original play scenarios, play was observed when children acted out scenarios, and their responses to each issue were rated. When the children participated in the evaluation a year and a half later, the same method was used. It was noted that the children with more creativity in their original play scenario rated even higher in their follow up. The children that were more imaginative were able to be more creative when looking for a solution in stressful situations.

Long-term effects of play. Play has been consistent in childhood throughout the generations. However, there are some instances where a child cannot play based on the environment where the child lives, and may not get the benefits that play gives to children. In Fearn and Howard's (2012) study, the researchers looked at the similarities and differences in situations where children have either never played, are prevented from playing and where they have played and how therapeutic play can benefit those children. While Fearn and Howard (2012) looked at applying therapeutic play, Fiorelli and Russ (2012) looked at how normal level play impacts a child. Therapeutic play has been used in situations where the child is undergoing various stressors and its main purpose is to improve the child's well being. Fearn and Howard (2012) evaluated three previously conducted studies where therapeutic play was used with children that had been abandoned, orphaned, or were deemed aggressive. Fearn and Howard (2012) did not conduct these studies, but observed the powerful impact of beneficial play in each

study. When working with aggressive children, the original researchers used structure and dramatic play intervention. To combat the aggression that many of the children displayed, exhausting physical games were encouraged so the children could burn off energy without losing control. These children's earlier life experiences of disciplined social control combined with opportunities of play later resulted in them learning how to cope. Another study that Fearn and Howard (2012) reviewed worked with abandoned children who were then given individualized attention which led to the children playing with objects in their new environment. The final study that Fearn and Howard (2012) researched involved children who were never limited in their play and those children functioned well and had high self-esteem. When Fearn and Howard (2012) looked at these three case studies, it was noted that therapeutic play did help the children in each case. While each independent study occurred in a different part of the world and during a different decade, looking at the three responses to therapeutic play showed that it was beneficial to children.

In comparison, Fiorelli and Russ (2012) observed children that had no major stressors in their lives apart from school. The children that Fiorelli and Russ (2012) focused on were judged only on their level of imagination. In that study, the children who did better in the play simulation and showed higher levels of imagination in the initial study later reported having a better life perspective than children with lower levels of imagination. While the purpose of play in both of these studies differ, both studies concluded that play was beneficial for children.

As mentioned in Fearn and Howard's (2012) study adaptive systems are what are effected by play. These systems include learning, the regulation of emotion, pleasure, enjoyment, positive feelings, creativity, the ability to make connections, and response to stress. In conditions of extreme stress and deprivation, as seen in the three studies that Fearn and Howard (2012)

analyzed, all of the children were able to regulate emotional arousal and bring down anxiety levels during play. Additionally, in Fiorelli and Russ's (2012) study, imagination in play in the beginning of the study significantly related to the frequency of coping responses at the end of the study. It was concluded that coping and play is maintained over time, and children with more imagination in play generated more solutions to challenging situations months after the study.

Success of workshops in teaching coping skills. Part of the development of children has to do with the growth and progress of their social skills. While most of the focus has to do with the proper way to communicate with others and general skills there is a way to implement the constant presence of peers children have throughout their schooling years. Peers can be a big influence when it comes to children and how they learn and behave. One of these skills can be how the child expresses and deals with their anger and aggression. A study done by Prinz and Blechman (1994) evaluated the effects of using peer coping skills training in regards to childhood aggression. In this study, the intervention was based on a coping competence model that addresses the development of antisocial and asocial coping among youth at elevated risk for conduct disorder. The aggressive children receiving peer coping skills training showed a significant improvement in observed prosocial coping via information exchange compared with the aggressive children in the no peer coping skills condition who showed no improvement. For aggressive children, peer coping skills training produced a significant reduction in teacher rated aggression compared to no peer coping skills training (Prinz and Blechman, 1994). To prove the long term effects of the intervention the follow up assessment the following year revealed that the aggressive children who had received peer coping skills training showed significantly higher prosocial coping, significantly lower aggression, and gains in social skills (Prinz and Blechman, 1994).

In addition, Prinz and Blechman (1994) also examined children who were competent and non-aggressive. Those who participated in the training showed no increase in either aggression or internalizing problems and no decrease in social skills and peer acceptance. The competent non-aggressive children who participated in peer coping skills training did not exhibit any adverse effects and showed significantly greater improvement in observed prosocial coping (Prinz and Blechman, 1994). For the competent non-aggressive sample, no significant increase in aggression or decreases in information exchange and social skills occured (Prinz and Blechman, 1994). Using peers to help those children with aggressive tendencies learn to develop improved coping skills proved to be successful and indicates that it not only takes a one on one effort with the child but also the integration of peers to change a child's tendencies and social skills. However, peers are not the only factor that set the stage for a child's ability to cope.

Early experiences and relationships in the family, kindergarten and school set the stage for how a child develops social and emotional skills, such as the ability to manage emotions, form and maintain positive friendships and cope with difficulties. Learning social and emotional skills is considered to be similar to learning academic skills in that the effects of initial learning are enhanced over time to address the increasingly complex situations that children face.

Examined by Mishara and Ystgaard (2006), the program, Zippy's Friends, is for preschool and first grade children. Zippy's Friends focuses on training children to cope with everyday adversities and negative life events. Rather than focusing on helping children to cope individually with their own problems, the program emphasizes the importance of talking to others, listening, as well as giving and receiving help. Repetition is used to reinforce the learning of key elements. The results of this evaluation indicate that Zippy's Friends has the significant short-term effects of improving children's abilities to cope with everyday adversities, increasing

some social skills and empathy, and decreasing behavior problems (Mishara and Ystgaard, 2006). An interesting positive side effect for the children participating in the Zippy's Friends program was the decrease in behavior problems (hyperactivity and externalization). Overall, children had an average enjoyment of the sessions. Although all children did not actively participate in each session, for example by engaging in the role plays, all of the children did participate actively in many different sessions throughout the course of the program (Mishara and Ystgaard, 2006).

The program of Zippy's Friends shares similarities with Prinz and Blechman's (1994) study. Both indicate that the children benefited from using techniques involving peers to improve social skills, even though the techniques involve slightly different methods. While both interventions helped to fundamentally change the children's social skills, Mishara and Ystgaard (2006) emphasized that the results were based on a short term evaluation and not a long term evaluation that was included in Prinz and Blechman's (1994) study. However, despite this discrepancy both interventions concluded that there was an overall benefit to the program.

Conclusion

We explored what happens to children who have parents who have experienced trauma. Those who have experienced trauma firsthand experience the repercussions long after the trauma has ended. A traumatic event can influence individuals who never experienced the trauma first hand in ways that can be almost as debilitating as first-hand trauma. Children who experience secondary trauma are more likely to be impacted by the trauma well into their adult lives. Given the research demonstrates that consistent positive reinforcement can help modify the disruptive behavior of children, and that peers can be very influential in the lives of children, it is important to develop positive reinforcement programs that are administered by children within peer groups.

In addition, research demonstrates that using play to act out scenarios helps children to advance their coping skills in those situations, therefore, it is important to apply some of these principles when helping those children with secondary trauma develop better coping skills.

Project Proposal

Children often encounter situations in life that will impact them, both psychologically and emotionally. Specifically, secondary trauma passed on from a parent may cause the child to internalize his or her problems, act out, and even develop negative coping strategies. When a child encounters a stressful situation, oftentimes the child attempts to self-soothe. Negative forms of soothing include withdrawing from people, avoiding people and situations that may cause stress, impulsive actions, and substance abuse.

For our grant, we would like to create a series of ten workshops that are aimed at teaching twenty children ages nine to twelve years old how to deal with stress and develop better coping skills. A series of workshops, offered every other week during the school year starting in the fall, can teach the children to develop active coping skills when a problem arises in their lives, as well as teaching children about how negative life experiences can affect their loved ones, and how to be understanding of their parents or other family members' behavior. By teaching children active coping strategies through play, children can build healthy coping strategies that will benefit them throughout the child's life. Developing better coping skills will help the child learn to navigate difficult social situations with their friends and family, and in turn limit the further transmission of indirect trauma to future generations.

Population

Children who are at risk of being impacted by secondary trauma will benefit from the program. We will be inviting children ages nine to twelve who have a parent who is a client of The Second Step or The VA of Jamaica Plain to be in this program. The participants will be going through the program at an age where they can develop positive coping techniques through play. For our pilot program, we will be inviting twenty children to participate in the program. To reduce the size of the group, the children will be divided into two groups of ten so that children can have more individualized time with the group leaders.

Staff

The grant writers are the program managers and will be responsible for hiring the staff. There will be an application (Appendix A) process as well as interviews. Each staff member will be CORI checked, as they will be working with children. We will be using the CORI form as seen in Appendix B. Staff members will complete a first aid and CPR course prior to the start of the program so that in the case of an emergency someone can administer first aid until a medical professional can arrive.

There will be nine staff total, including Christine LaBelle and Korinna Locke. Korinna Locke and Christine LaBelle will be program managers and daily operations managers. The program and operations managers duties will be to supervise all employees, keep track of paperwork, hire staff, organize schedules for staff, customer service, and keep inventory of and order food, beverages, and supplies.

Staff also includes two specialists in play therapy with children who will be responsible for conducting groups. The specialists will be required to have a doctoral degree, with seven years of experience, and a license to practice therapy. Experience working with and teaching

children is preferred. Staff also includes a professional specializing in talking with children who are dealing with secondary trauma. The professional will be required to have a doctoral degree, with seven years of experience, and a license to practice therapy. Experience in educating others on topic is preferred. The professional will be needed only for two sessions of the program. In addition, we will hire four interns responsible for set up of activities, cleaning up for activities, snacks and attendance. The interns will rotate helping with both groups. Two will be with the groups one week and the other two will be helping with set up and clean up and then the following week they will switch. Experience in psychology and theater related majors is required.

Recruitment and Participation

We will recruit the children, aged nine to twelve, of clients from both the VA hospital of Jamaica Plain and The Second Step of Newton. Parents diagnosed at the VA with trauma related illnesses receiving outpatient treatment will help to indicate if their child qualifies. All children from The Second Step will qualify. An information session will be held at both locations informing parents about the program, the benefits, and the participation of both agencies. After we inform the parents about the program, we will offer parents the opportunity to sign their child or children up for the workshop. For The Second Step families, only the mothers will be given the information session. If the mothers' are required per custody agreements to inform the fathers about the child's participation in the program, one of the directors of the program, Christine LaBelle or Korinna Locke, will contact the father and inform him about the program. Only the mother will be required to sign the permission slip.

At both information sessions, there will be brochures detailing the program so that parents can review the program with their spouses or family members when deciding if they will

allow their child to be included in the program. Parents will fill out a permission slip, as seen in Appendix C. We hope to make this program free and accessible to as many people as possible. At the information sessions, we will also have copies of the session itinerary for the program so that parents will know what their child will be doing. Parents are welcome to ask questions about the session content at the information session or contact a program director.

Transportation

Transportation will be available for children from The Second Step. Parents or family members from the VA are responsible for transporting the child to the location, and will be informed that they are responsible for drop off prior to the parent's enrolling the child in the program. There is no space available at either site, which makes renting a third location a requirement for this program. If The Second Step children are a part of the afterschool program that The Second Step provides, then we will ask a member of the after school program to drop the children off at the program location. Since it is likely that the fathers' of the children involved in The Second Step will know their children will be in the program, we do not want the mothers of those children to be at risk of encountering their abuser. Neither parents of The Second Step will be allowed to pick up their children from the program for the reason of limiting interaction between the two parents, and we will ask The Second Step afterschool program to bring the children back to Newton. If The Second Step staff cannot accommodate, then we will seek alternative solutions. Transportation agreements will be worked out between the directors and The Second Step staff soley. If further difficulties arise in getting the child to the program, we will assist families by covering the cost of a taxi, if the parent wishes their child to ride in one.

Afternoon snack

In addition to transportation and as the program will be occuring after school hours, it is likely children will be hungry once they get to the program. Prior to the program beginning, we will offer different healthy snacks each week, taking into consideration any allergies. We will also offer a beverage choice of either water or juice. We will be purchasing either fruit or vegetables from a local grocery store the morning of the program and a staff member will clean and prepare the snack prior to children arriving. Prior to the start of the program, parents will be asked to fill out an allergy form, as seen in Appendix D, so that the program directors are aware of any food allergies and can plan accordingly. If the parents do not want their child to have the provided snack, they are made aware that they can pack a snack instead.

Location

The workshop will be at a neutral location, halfway between Jamaica Plain and Newton to make the workshop easily accessible for both populations. Neither The Second Step or the VA Hospital has adequate space available for the program. We will be renting a space, most likely from a function hall, so that the location is neutral. The ideal space will have a common area for all the children to gather as well as the ability to have two separate rooms or areas to divide the children into a younger group and an older group. Before signing a rental agreement, we will be touring locations as well as taking into consideration if the space is adequate for the amount of children we anticipate will be enrolled in the program.

Program Sessions

The program will meet every Wednesday afternoon for ten weeks. There will be a total of ten sessions for the pilot program. The workshops will be two hours long, from four to six in the evening. The workshops will run during the school year in the fall months. The reasoning behind this time is that when the children are returning back from the program, their parents may also be

off work by then, which would make transportation home for the children of the VA easier. Also, finding staff members on the weekend will be challenging, as our professionals we will be hiring may have other, full time jobs. Furthermore, by having the program on a Wednesday evening, finding a location will be easier since other programs will likely not be running during that time slot. Each session will target a different topic, such as conflicts at school, family disagreements, and stress. These topics will be discussed and different scenarios that can happen relating to them will be examined. To do this the staff will be using play as an outlet to act out scenarios with the children and help the children develop better coping and social skills. A sample itinerary can be seen in Appendix E. During the first and last session we will be having a trauma therapist explain to children trauma so they can understand more about their family members and what they go through. The trauma specialist will run through their program with the program coordinators to approve the content so that it is appropriate for the children.

Evaluation

After the program ends we will evaluate the program based on the responses from both parents and children in surveys administered immediately after the completion of the program. We will ask parents to report on their child's behavior and appearance and see if the program made an impact on the children. We will be asking the children and their parents for feedback to determine if the program was a success. We will be providing the children and parents with evaluation forms as seen in Appendix F. We will send out the evaluations to the parents to complete a month after the program has finished and provide postage for the families to send the surveys back. We will hire a statistician to evaluate the results of the responses on our surveys. Based on the responses from parents and children, adjustments will be made to the program as needed and the duration will be extended. In the case of the program being renewed the duration

will be extended and children may attend the program for multiple years. If this occurs the parents and children will be given an improved evaluation form to ascertain the impact on children for a longer duration. By the end of the pilot program, the hope is that parents will notice an improvement in how the children handle situations and that the children will report that they felt that they learned something new in the program.

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Applicant Information			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	Zip	
Phone	E-mail		
Date Available	Social Security No.	Desired Salary	
Position Applied for			
Are you legally eligible to work in the U.S.? Yes ☐ No ☐			
Have you ever worked for this company? Yes ☐ No ☐ If yes, when?			
Have you ever been convicted of a felony? Yes ☐ No ☐ If yes, explain.			

Education			
High School		Address	
From To	Did you graduate?	Yes ☐ No ☐	Degree
College		Address	
From To	Did you graduate?	Yes ☐ No ☐	Degree
Other		Address	
From To	Did you graduate?	Yes ☐ No ☐	Degree

Employment History		
Company		From To
Address	Phone #	
Supervisor	Responsiblities	
May we contact? Yes ☐ No ☐		
Company		From To
Address	Phone #	
Supervisor	Responsiblities	
May we contact? Yes ☐ No ☐		
Company		From To
Address	Phone #	
Supervisor	Responsiblities	
May we contact? Yes ☐ No ☐		

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References

Full Name	Relationship
Company	Phone #
Address	
Full Name	Relationship
Company	Phone #
Address	
Full Name	Relationship
Company	Phone #
Address	

Disclaimer and Signature

I certify that the information contained in this application is correct to the best of my knowledge. I understand that to falsify information is grounds for refusing to hire me, or for discharge should I be hired.

I authorize any person, organization or company listed on this application to furnish you any and all information concerning my previous employment, education and qualifications for employment. I also authorize you to request and receive such information.

In consideration for my employment, I agree to abide by the rules and regulations of the company, which rules may be changed, withdrawn, added or interpreted at any time, at the company's sole option and without prior notice to me.

I also acknowledge that my employment may be terminated, or any offer or acceptance of employment withdrawn, at any time, with or without cause, and with or without prior notice at the option of the company or myself.

Signature	Date

job-applications.com
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Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Facility Licensure and Certification
99 Chauncy Street, 11th floor, Boston, MA 02111
617-753-8000

Criminal Offender Record Information (CORI) Acknowledgement Form

The Department of Public Health, Division of Health Care Facility Licensure and Certification, is certified by the Department of Criminal Justice Information Services (DCJIS) to screen applicants for licenses to operate health care facilities and programs. As a licensure applicant, I understand that a CORI check will be submitted to DCJIS for my personal information. I understand that a criminal offender record information (CORI) check will be conducted for conviction and pending criminal case information, only, and that such information will not necessarily disqualify me. The information below is correct to the best of my knowledge. I hereby acknowledge and provide permission to submit a CORI check for my information to the DCJIS.

Signature ____________________ Date ____________________

*Last Name ________ *First Name ________ Middle Name ________ Suffix ________

Maiden Name (or other name(s) by which you have been known) ____________________

*Date of Birth, mm/dd/yyyy ________ Place of Birth ________ XXX /   /   *Last Six Digits of Your Social Security Number

Sex ☐ M ☐ F   Height ____ ft ____ in   Eye Color ________ Race ________

Driver's License or ID Number ________ State of Issue ________

Mother's Full Maiden Name ________ Father's Full Name ________

Current Address

Street Number & Name ________ City/Town ________ State ____ Zip ____

Former Address

Street Number & Name ________ City/Town ________ State ____ Zip ____

DPH/DHCFLC use only. The above information was verified by reviewing the following form(s) of government-issued identification:
Name of Verifying Employee (Please Print) ________ Signature of Verifying Employee ________

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Facility Licensure and Certification
99 Chauncy Street, 11th floor, Boston, MA 02111

617-753-8000

CORI

The Department of Public Health (Department) is required to conduct suitability reviews for all applicants applying for licensure as new health care providers. The review includes a criminal background check of the applicant. Accordingly, The Department has been certified by the Executive Office of Public Safety, Criminal History Systems Board, for access to reports from the criminal offender record information system.

The enclosed Criminal Offender Record Information (CORI) form must be completed and returned with the license application for all individuals (use full names) identified below so that determinations of suitability and responsibility can be made in a timely manner.

- All individuals who hold a 5% or greater ownership or managerial interest in the facility;
- If the applicant is a partnership, CORI forms must be completed for all general and limited partners with 5% or greater ownership interest in the partnership;
- If the applicant is a for profit corporation, CORI forms must be completed for all officers, directors and holders of 5% or more of the corporation's stock;
- If the applicant is a not for profit organization, CORI forms must be completed for the officers of the board of directors, the executive committee, or other such governing body that has direct and ultimate control over the operation and compliance performance of the facility.
- The program administrator.

In order to verify the information on your CORI request form, you may either (1) deliver your application to us in person, at which time we will verify the information on your request form, or (2) include a photocopy of a government-issued photographic identification with your request form.

Government-issued photographic identification includes, but is not limited to: state issued drivers license, state issued photographic identification card, passport, or US military ID. We are not able to accept an identification card issued by a private employer or, with the exception of a passport, by a non-US or state government agency.

If you have any questions or concerns regarding the completion of these CORI forms please contact Pearlina Mills (617) 753-8124.

Appendix C

Parental Permission for Participation of a Child in Play Therapy Group

Description of program and your child's participation

Your child is invited to participate in a new program that uses play therapy to help teach children how to better navigate social situations. The purpose of this program is to help teach proactive skills to children so that when they encounter stressful situations they can confidently respond without feeling overwhelmed.

Your child's participation will involve going through scenarios, such as what to do when the child has a fight with their friend, asked to act the scenario out and their response to the situation, and then will talk to the group and the leaders about what happened in the situation and how they could have handled the situation a different way. In addition to using play therapy, two trauma therapists will come to the program and talk to the children about the effects of trauma on individuals and their loved ones.

The program will be held on alternating Wednesday afternoons. There will be ten sessions total. Each child will be given a snack at the beginning of the program.

Risks and discomforts

Your child may feel uncomfortable talking about some of these situations. At the end of each session, there will be a time dedicated to debriefing what happened within the group. If the child feels uncomfortable at any point during the program, they are encouraged to come talk to a staff member, or not participate in that given situation.

Potential benefits

The benefits from play therapy are that the children can better handle real life scenarios. By going through simulated situations and having other people to talk to in the fake scenario, the child will be able to handle a real life situation comfortably and confidently.

Voluntary participation

Participation in this program is voluntary. You may refuse to allow your child to participate or withdraw your child from the program at any time. Your child will not be penalized in any way should you decide not to allow your child to participate or to withdraw your child from this program.

Contact information

If you have any questions or concerns about this study or if any problems arise, please contact Christine LaBelle or Korinna Locke at clabelle@lasell.edu or klocke@lasell.edu

Consent

I have read this parental permission form and have been given the opportunity to ask questions. I give my permission for my child to participate in this study.

Parent's signature________________________________ Date:_________________

Child's Name:____

Appendix D

Food Allergy/ Intolerance Form

Student Name:

Completed by: Relationship to student:

If we have further questions about this allergy how can we contact you:

____

Please provide as much detail as possible when completing this form. An allergy is an immune system response to a substance known as an allergen. For example, allergens can be foods, insects, medication and plants. A food intolerance is an unpleasant digestive response to a food.

Please list any known allergies:

____

____

____

What is the student's reaction to the allergen(s)? (For each one, please give as much detail as possible)

____

____

____

What treatment should be provided if the child is exposed to the allergen?

____

____

____

Any Epi- pens, inhalers or emergency medication must be made known to staff so we can appropriately act in case of an emergency.

____

____

If the allergen is food, what would the student's reaction be if they:

Are in the vicinity of the food:

____

____

____

Touched the food:

____

____

____

Ingested the food:

____

____

____

Ate items processed in the same factory as the allergen:

____

____

____

Please list any known food intolerances and provide information as to how the intolerance is managed.

____

____

____

We will do our best to accommodate the student's allergies. If the allergy is complex, requires an entirely different diet or is extremely severe, we may ask that you provide food for snack time each day that your child attends the program. If you have any questions, please contact Christine LaBelle or Korinna Locke at clabelle@lasell.edu and klocke@lasell.edu.

The above information is correct to the best of my knowledge. I am aware that my child will be given an afternoon snack at the program that he or she will be attending. If I do not feel comfortable with my child having the program supplied snack, I will pack my own for my child to consume. I understand that the staff members are trained in first aid, but are not nurses or doctors.

Parent signature:____

Childs name:____

Appendix E

Program Session Itinerary

Session One

-Check in and snack time

-Break up into groups of ten

-Name games and introductions to meet other group members

Children will introduce themselves to one another and their group leaders. They will stay with their group for the duration of the program, making it important to learn each other's names.

-Trauma specialist talks to kids

The children who are enrolled in this program are at risk of developing trauma. It is important that the children understand trauma is not any one person's fault and that trauma affects many different people. Having an overview of what trauma is can help answer some children's general questions such as what it is, what it does to people, and why it is important to understand. Children will be able to write down questions on a piece of paper and put it in a hat, and the trauma specialist will answer the questions. By having the children write the questions down, each child can ask what he or she wants to know and remain anonymous.

-Debrief session

At the end of each session, group leaders will save fifteen minutes to go over what happened during the session. Group leaders will highlight the effective strategies that the children used and offer insight as to how a situation could have better been handled.

Session Two

-Check in and snack time

-Break up into groups

-Play group topic: Fights with friends

This week children will be focusing on scenarios revolving around fights with friends. The first exercise during the session, each child will talk about a time that he or she had a fight with a friend and explain what the fight was about, what happened, and if they resolved the problem. Then, children will pair up and talk to a partner and act out one of the examples that they had given. They will act out the fight that they had encountered in front of the group, and then for the next five minutes, the group will talk about what the children could have done differently. Then, the following exercise will be an “ideal fight” scenario. The kids will improvise a new fight and then practice how they could handle the fight. Again, after each scenario, the group will talk about what was done well and what could be done differently.

-Debrief Session

At the end of the session, group leaders will recap what happened during the scenarios, and talk about some good ways of handling a fight with a friend. Children will be encouraged to ask questions and give feedback on how the scenarios were handled.

Session Three

-Check in and snack time

-Break up into groups

-Play group topic: Emotions

In this session, children will play games identifying emotions. In a charades-style game, children will act out an emotion without talking, and other children will guess the emotion. In the

next activity, the children will each name a time where they felt a specific emotion. For example, the group leader will ask the children to describe a time they felt mad, and they will tell the group about the experience, why they felt that way, and what happened after the situation. The group leaders will spend time talking to the children about what they can do when they feel mad, or sad, or hurt. By talking about emotions and ways to handle them, the children can reflect on emotions that they have felt in everyday life and learn how to better manage those emotions.

-Debrief Session

The group leader will talk with the children about the different emotions they talked about, and reinforce the positive ways that the children can manage those feelings. The children will be encouraged to explain the ways that they will manage these emotions, rather than the group leaders, so that it is more impactful and they are critically thinking about how to handle those feelings, rather than just listening to the group leader.

Session Four

-Check in and snack time

-Break up into groups

-Play group topic: Fights with Family

At the beginning of the session, the children will be asked to reflect on a time they fought with a family member and describe the experience; why they fought, how it made them feel, and how they made up. The children will then break up into small groups of three or four within their group of ten and pair with a staff member to create a fake scene of a disagreement with a family member, such as a mom, brother, or aunt. After they put on the skit, the group will stop after the fight, as if on pause. The remaining children and group leaders will give suggestions to the group

on how they can make up with the family member in the scene. The group will resume acting, taking what the other children said and using that to make up for the scenario.

For the second activity, children will reflect the week before about emotions and talk about what emotions they feel when having a disagreement or fight with a family member. The group leader will ask the children if anyone has had a disagreement within the last week with a family member and if so, how they felt and how they may have managed their feelings. By incorporating previous sessions with current sessions, the group leader is reinforcing positive social and coping skills.

-Debrief Session

The group leader will recap the activities and go over the positive ways that the groups handled their scenes. The group leader will mention if there are any other ways that the children could have handled the situations and ask the children to tell each other what they thought one another did well to promote the social relationships developing between the children in the group.

Session Five

-Check in and snack time

-Break up into groups

-Play group topic: Bullying

Bullying is a topic that is crucial to focus on. It is important to help children cope with being bullied, but also encourage children to stand up for someone else they see being bullied. The children will be asked to share a time they either saw someone being bullied or was bullied themselves. The group leader will not make anyone talk, and if children do not feel comfortable

sharing, the group leaders will give examples of bullying. Children will be asked to describe what emotions someone that is bullied may be feeling. By talking through the emotions, they can reflect from previous sessions ways to cope with those feelings.

From there, kids will act out what they would say to a bully and practice how to stand up for themselves and for others. Rather than letting a bully have power over them, the children can feel confident in controlling situations that may be difficult for them. Even though this is not a coping situation, it is important to know how to handle difficult situations so the children do not feel overwhelmed.

-Debrief Session

Bullying can be a difficult topic to talk about, especially if a child feels embarrassed that he or she has been bullied. The group leader will spend twenty minutes instead of fifteen talking about this session because of how emotional it can make the children. The group leader will review the activities, but also praise the children for their thoughtfulness and reinforce how well they handled the scenarios that they practiced.

Session Six

-Check in and snack time

-Break up into groups

-Play group topic: School Stress

School comes with many different stressors, from social situations to academic stress. Since this is such a wide topic, the group leaders will ask children about what stresses them out at school. They can choose to either describe it or act it out. From there, the leaders will walk the children through how they can better manage that stress by performing calming techniques or interacting with the stressor directly. By teaching the children to confront their stresser in a

positive way, it can empower the children to feel as if they have more in a say in the outcome of the situation. By using acting to go through hypothetical situations and talking through them with the group, the children can feel more prepared to handle school stressors.

-Debrief Session

Recapping what was talked about in the session is always important, but now that it is week six, the group leader will be asking the children if they have encountered any of the situations that the group has talked about and how the child handled that situation in real life. By allowing for the children to report back that these methods are working, we can be sure our program is working.

Session Seven

-Check in and snack time

-Break up into groups

-Play group topic: Self-esteem

Self-esteem is something that gets affected when children start to go through puberty and may be impacted based on the child's situation at home. Rather than acting out how to have better self-esteem, the group leaders will dedicate this session to talking about what self-esteem is, and how to have a healthy level of self-esteem. This week we will allow for children to have an art project reflecting their positive self-esteem. They will use recycled magazines to cut out positive words and make a collage of positive words so that they can look at it and reinforce self-esteem.

-Debrief Session

The debrief will be spent by having the children talk about their art pieces and why they chose to add specific words. Children will be encouraged to give feedback to each other and say nice things about each other to show how positive relationships can impact another person's self-esteem.

Session Eight

-Check in and snack time

-Break up into groups

Peer-pressure is a reoccurring stressor that can happen in an individual's age, regardless of their age or their backgrounds. When children encounter environmental stressors, whether at home or at school, they will cope to deal with their surroundings. By learning how to handle the stressors caused by the children’s peers, they can be better adapted when going against peer pressure, either brought on by one individual or a group. The nature of peer-pressure remains the same, but the scenarios change based on the age the child is when encountering it. The group leader with psychology experience will determine what scenarios are age appropriate for the group. For the activity, the group will divide into pairs and practice saying no to one another after the group leader discusses peer pressure. The staff will walk around and monitor the children’s scenes with one another. An additional activity will be conducted if there is time remaining, and the group leader will decide what to do based on the group’s reaction to the first activity.

-Debrief Session

At the end of the session, the children will share how the exercises made them feel, and they will be encouraged to share any fears about peer pressure. As this is a difficult topic to

approach, due to the possibility that some of the children have not yet encountered peer pressure, the group leader will rely on his or her experience when debriefing the children.

Session Nine

-Check in and snack time

-Break up into groups

-Play group topic: Crushes

Crushes develop in children at different times, but it is likely that many of the children in the group have experienced a crush at some point in his or her life. The first part of the session will be dedicated to talking about crushes and that crushes can be opposite or same sex. The parents will be informed prior to this session that we will be discussing same and opposite-sex attraction so they can have the opportunity to talk to their child about sexuality prior to the group. The group will be a safe environment where all sexualities are accepted and encouraged.

For an activity, rather than acting, the students will be given toys to put on a pretend to show, and each child can demonstrate how they think they should talk to a crush. The group leader will provide feedback and offer insight on if the communication the child shows is appropriate. Far too often, children can be mean to those they have a crush on, and the group leader will cover topics such as respect when discussing crushes with the group.

-Debrief Session

Most of the briefing will occur as the activity and discussion happen, but there will be time reserved for the children to ask questions about crushes and sexuality. Crushes can be an intimidating social interaction that can be considered a stressor, so it is important to have as many open conversations about the topic as possible

Session Ten

-Check in and snack time

-Break up into groups

-Play group topic: Children's choice

Children will spend the first hour acting out scenarios of topics they want to spend more time for the last session. After being in the program for ten weeks, the kids can talk about which topics they wish we had spent more time on and revisit them.

-Trauma therapist comes back and talks more about trauma

At the beginning of the program, a trauma specialist came in and gave an overview of trauma and the effects on loved ones. After ten weeks, we would like the specialist to come back and answer any more questions the children may have about the topic. We would like the specialist to reiterate that trauma affects many individuals, and if someone has experienced trauma their reactions can vary. We would like the children to understand trauma but also not belittle it, and understand that trauma can make their parents resilient.

-Debrief Program

The end of the session will be spent asking the children what they learned and what they found valuable from the program. The children will have the opportunity to fill out the evaluation form and give it back to staff members so that our program can be improved for future years. We will ask the children what sessions were their favorite and if they have used any of the techniques we have taught them in real life. This is important feedback so that our program can become more beneficial for future children.

Appendix F

Parent Evaluation Form:

The program was easy to get to

Strongly Disagree Disagree Neutral Agree Strongly Agree

Does Not Apply

The program was at a convenient time

Strongly Disagree Disagree Neutral Agree Strongly Agree

Does Not Apply

My child talked to me about the program

Strongly Disagree Disagree Neutral Agree Strongly Agree

Does Not Apply

I noticed my child handle difficult situations more easily

Strongly Disagree Disagree Neutral Agree Strongly Agree

Does Not Apply

Before this program, my child had behavioral issues.

Strongly Disagree Disagree Neutral Agree Strongly Agree

Does Not Apply

After this program, my child acted out less at home.

Strongly Disagree Disagree Neutral Agree Strongly Agree

Does Not Apply

Before this program, my child had behavioral issues at school.

Strongly Disagree Disagree Neutral Agree Strongly Agree

Does Not Apply

After this program, my child was having less behavioral issues at school.

Strongly Disagree Disagree Neutral Agree Strongly Agree

Does Not Apply

Prior to this program, my child had been diagnosed with anxiety, depression, PTSD, or another mental health issue.

Strongly Disagree Disagree Neutral Agree Strongly Agree

Does Not Apply

After this program, my child showed less symptoms of their mental health issue.

Strongly Disagree Disagree Neutral Agree Strongly Agree

Does Not Apply

Child Evaluation Form

I had fun at this program

Strongly Disagree Disagree Neutral Agree Strongly Agree

I made new friends at this program

Strongly Disagree Disagree Neutral Agree Strongly Agree

I learned something new at this program

Strongly Disagree Disagree Neutral Agree Strongly Agree

I want to come back to this program

Strongly Disagree Disagree Neutral Agree Strongly Agree

I talked to my family about this program

Strongly Disagree Disagree Neutral Agree Strongly Agree

I talked to my friends at school about this program

Strongly Disagree Disagree Neutral Agree Strongly Agree

I found this program useful

Strongly Disagree Disagree Neutral Agree Strongly Agree

This program taught me how to handle situations better

Strongly Disagree Disagree Neutral Agree Strongly Agree

This program helped me feel less stressed when I would get into a disagreement with a friend or family member, or when something stressful happened at school

Strongly Disagree Disagree Neutral Agree Strongly Agree

Budget

Supplies

Item	Units	Price per Unit	Total Price
Paper cups	1 pack of 50 cups	$50.49	$50.49
Plastic forks	4 boxes of 100 forks	$3.99	$15.96
Napkins	1 package of 400 napkins	$4.49	$4.49
Paper plates	3 packages of 125 plates	$13.49	$40.47
Paper	1 case	$45.99	$45.99
Crayons	3 boxes of 64 crayons	$5.99	$17.97
Markers	3 boxes of 10 markers	$6.59	$19.77
Paper towels	1 package of 15 rolls	$13.99	$13.99
Trash bags	1 box of 100 bags	$15.99	$15.99
Lysol wipes	1 packages of 3 containers	$21.99	$21.99
First aid kit	1 kit	$49.99	$49.99
Glue sticks	1 pack of 30	$11.99	$11.99
Magazines	10 magazines	$3.99	$39.90

Category Total $348.99

Food

Item	Units	Price per Unit	Total Price

Juice boxes	46 packages of 8 juice boxes	$2.50	$115
Water bottles	15 cases of 24 bottles	$2.99	$44.85
Apples	100 apples	$1.39	$139
Bananas	40 bananas	$1.99	$79.60
Grapes	10 bags of grapes	$5.99	$59.90
Pears	100 pears	$1.25	$125
Oranges	100 oranges	$1.00	$100
Baby carrots	10 packages	$1.99	$19.90
Celery	10 packages	$1.99	$19.90
Ranch dressing	5 bottles of ranch	$2.79	$13.95

Category Total $717.10

Equipment

Item	Units	Price per Unit	Total Price
Laptop	2	$249.99	$499.98
Dolls	20 dolls	$9.99	$199.80

Category Total $699.78

Personnel

Item	Number of employees	Wage	Number of hours or times of service	Total Expense

Statistician	1	$40/hr	40 hours	$1,600
Interns	4	$15/hr	4 hours/week for 12 weeks	$2,880
Play therapy Specialist	2	$70/hr	4 hours/week for 12 weeks	$3,360
Trauma Psychologist	1	$45/hr	8 hours	$360
Program Manager	2	$60/hr	20 hrs/week for 20 weeks	$48,000

Category Total $56,200

Miscellaneous

Travel	Taxi money for transportation exceptions		$500
Rent	Church of the Redeemer in Chestnut Hill in the undercroft room	4 hrs for 10 weeks Rent per session is $100	$1,000
Advertising: Posters, brochures and copies of session plan	25 Posters to be located at VA Boston and Second Step 50 Brochures to be given at informational sessions 50 Copies of Program Session Plan to be given at informational session All supplies from staples	Posters: $9.99 each 1 package of 25 brochures: 24.99 each Copies:11 per page with 9 pages total	$349.20
Printing costs	Allocated money for if we need to send any additional things to be printed		$100
Envelopes for mailing	2 boxes of 50 envelopes	$2.89	$5.78
Postage for evaluations to be returned	1 roll of 100 stamps	$50.00	$50.00

Category Total $2,004.98

Grand Total: $59,970.85

Christine LaBelle's Biographical Statement:

Christine LaBelle was born on December 7th, 1995 in Framingham, Massachusetts. She is attending Lasell College and anticipates graduating in May 2018 with a Bachelor of Science degree in psychology and a minor in forensic studies. After graduation, she intends to work full time to gain more experience in research before applying to graduate school. In her spare time, Christine likes to spend time with family and friends, read, and relax.

Christine LaBelle

310 Summer St. Framingham, MA 01701 | (774) 270-3270 | Christine.LaBelle99@gmail.com

Summary

Motivated psychology student with experience in research, customer service, conflict resolution and management. Recognized for leadership, organization, adaptability and teamwork.

Education

Lasell College, Newton, MA — May 2018 (Expected)
Bachelor of Science, Psychology — **GPA 3.89/4.0**
Minor in Forensic Studies
Dean's List | Honor's Program | Psi Chi | Presidential Scholar

ACG DEREE, Athens, Greece — Spring 2017

Related Coursework: Counseling and Case Management | Adolescent Psychology | Child Development | Human Services | Experimental Design in Psychology | Capstone Project

Experience

Assistant Manager, Lasell College Mail Room, Newton, MA — April 2015 – Present

- Relied upon by supervisor to manage mail room with one other student for duration of summer; acts as second in command when supervisor is not available; trains new employees; makes schedule for semester and breaks
- Provide customer service when answering phone calls and managing window pick-ups, as well as daily tasks

CHOIR Research Assistant Intern, VA Boston, Boston, MA — September 2017- Present

- Conduct literature review for manuscripts; Assist with IRB paperwork; Prepare study materials
- Contributed to recruitment; mailing letters, calling participants to screen and schedule
- Assist with CENC study visit; review questionnaires, conduct study assessments (NIH toolbox, Scan-3, Otogram, vital signs, and CDP)
- Score Neuropsychology tests and input data into Medidata
- Practiced conducting Neuropsychology testing (WAIS, TOPF, TMT, SVV, CVLT, GPB and DKEFS)

Intern, Rosemary B. Fuss Center, Newton, MA — September – December 2016

- Organized MGA membership files from the last several years, developed reports of membership patterns, and set up registration/membership files for the MGA Fall Policy Forum
- Coded qualitative response data from the Fuss research study on Intergenerational Exchange and Everyday Problem Solving; set up data files for linguistic analysis using LIWC, conduct LIWC analysis, conduct quantitative preliminary analysis using SPSS, provide analysis overviews
- Conducted information and literature searches as needed to support research and related work
- Assisted with the Bridges Together Program with Rockwell Child Student Center, Lasell Village, and Newton COA, and participated in the weekly program

Associate, Panera Bread, Wayland, MA — March 2013 – September 2014

- Trained at least five new employees on restaurant policy and procedures

Soccer Referee, Framingham United Soccer Club, Framingham, MA — September 2008 – September 2009

- Refereed games for soccer teams ages 10 and under; resolved conflict between players enforcing sportsmanship

Activities

Treasurer, Co-President, Outdoor Adventure Club — January 2015 – Present

- Contact local venues to inquire about various details for club events
- Meet with Student Government Association and Student Activities to negotiate semester budget
- Manage budget of $3,500, attend budget meetings and balance check book

Lasell Accepted Students Honors Program Speaker — March 2016
Greater Boston Food Bank, Boston, MA — November 2014
Hope for Humanity, Lasell College — November 2014
30 Hour Famine for World Hunger, Framingham, MA — October 2012

Skills

Microsoft Word, Excel, PowerPoint | Linguistic Inquiry and Word Count (LIWC) | SPSS | Medidata | EndNote
Intermediate knowledge of Spanish

Korinna Locke's Biographical Statement:

Korinna Locke was born on October 4th, 1996 in Norwood, Massachusetts. She is attending Lasell College and anticipates graduating in May 2018 with a Bachelor of Science degree in Sociology and a minor in Legal Studies. After graduation, she intends to continue her education by attending New England School of Law while working part time in a small firm located in Sharon, Massachusetts. In her spare time, Korinna likes to competitively show dogs, read, and spend time with friends and family.

KORINNA LOCKE
176 Hill Street, Norwood, MA 02062
(781) 686-7458 korinna.locke@gmail.com

EDUCATION

Lasell College – Newton, Massachusetts
Senior - GPA 3.9

ACADEMIC HONORS

Lasell College Dean's List - 7 Semesters
Lasell College Honor's Program
Lasell College Mock Trial Captain
Legal Society President
Lasell Presidential Scholarship Recipient

RELATED COURSEWORK

Sociology 101, Contemporary Social Problems, Human Services 101, Case Management, Legal Studies 101, Mock Trial, Constitutional Law, Legal Research and writing, Evidence

SKILLS

- Highly organized individual with a proven leadership and mentor skillset
- Pleasant and professional with the ability to communicate well with a wide range of personalities
- Proficient in the Microsoft Office Suite of applications including PowerPoint, Word, and Excel
- Knowledgeable in the concepts of and use of multiple social media platforms

WORK EXPERIENCE

The Second Step/Steps to Justice Intern **(September 2017—May 2018)**

- Assisting attorneys working with survivors of domestic violence by helping research cases as well as observing hearings
- Worked with Development team to promote events

Peer Mentor / Peer Advisor, Lasell College, Newton, MA **(September 2015 – Present)**

- Act as a mentor by attending first year seminar course to identify with and provide emotional support to a group of assigned students as they adjust to college life and experiences
- Provide advising services to first year student and students that are struggling academically to support their efforts of strengthening their college situation

Office Assistant for Andrew Nebenzahl, Esq. **(August 2017 – Present)**

- Assisting paralegal perform various activities, such as mailing, deposition summaries and submitting court documents
- Light filing

Office Assistant for Steven B. Rosenthal, Esq. **(January 2017 – Present)**

- Responsible for sorting through files to determine if they were active or inactive
- Organized the storage area for older case files
- Helped arrange the destruction of dead files

RoseMary B. Fuss Center Intern **(Fall 2016)**

- Responsible for reading journals and reporting findings back to supervisors
- Created independent projects for future Fuss Center use
- Drafted resource lists for multiple topics for future research

ACTIVITIES

Girl Scouts of Eastern Massachusetts, Norwood, MA Service Unit

- Silver Award and Bronze Award Recipient
- Life Time Girl Scout (2001 to Present)
- Adult Volunteer acting as mentor, role model, and leader to younger scouts

PROFESSIONAL ASSOCIATIONS

- Girl Scouts of Eastern Massachusetts
- American Mock Trial Association
- American Kennel Club
- West Highland White Terrier Club of New England

February 2018