

CARE CORPS INTERNATIONAL

Children's Care Division: Caregiver Reference Manual

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Mission

Care Corps International is committed to helping heal children affected by trauma through following Jesus Christ's example of practical and holistic care. Children are particularly vulnerable to great emotional and psychological damage in crisis situations such as disaster, conflict, and violence. By facilitating healing and reconciliation Care Corps strives to provide a substantial witness of the incarnational love of Christ.

It is our hope that through addressing the emotional, psychological, and spiritual needs of children affected by trauma, Christ's redemptive love be witnessed and received. In this way, children whose lives have been shattered and need spiritual, emotional, and psychological healing will receive the "cup of cold water" (Mt. 10:42) that comes through Jesus Christ our Lord.

Purpose

Care Corps International works at the invitation of local churches and mission and relief agencies to bring programs and training designed to facilitate restorative therapy to the hurting children of the world. By combining basic trauma counseling with play and art therapy in the context of a safe and secure environment, our desire is to begin meeting the enormous needs of suffering children through practical and proven methods.

Additionally, by following the principle given in II Timothy 2:2 we seek to train pastors, relief and mission workers, and lay-counselors to be better equipped servants of the Lord as they minister to hurting children.

This manual is intended to provide caregivers with a basic resource to better serve the needs of hurting children. By helping caregivers be more effective in their work with hurting children, the healing and redemptive love of Jesus will be more vibrantly witnessed and experienced by children in need.

Due to the great need of so many children affected by trauma, it is the collective responsibility of all caregivers to continually share resources in order to equip as many people as possible to be more effective caregivers. This resource manual is by no means exhaustive and should be used as a reference, not an authority.

We believe the best example of care comes from Jesus Christ's concern and devotion for all children. One of Jesus' most effective ways of ministering was by directly addressing needs. As we work with children who have been hurt, it is extremely important to follow in Christ's footsteps and lovingly attend to the needs of the hurting. As we work together

to share the healing and redemption in Jesus Christ, it is our prayer that the hurting children of the world will be healed and come to know their Savior and Lord.

Philosophy of Trauma Care

When a child has cut his leg we know the necessary steps to take for healing to occur. We also recognize that even after the appropriate care has been given, time must pass for the wound to heal. We care for the child, attending to the bandages and changing them when necessary. When the wound heals there often is a scar. In the same way, traumatic events wound people and children are no exception. In fact, children are often affected by trauma in different and more pronounced ways than adults. It can also be difficult to see exactly how a child has been hurt, which in turn makes it hard to know how to help.

Many caring people in the world have committed themselves to helping on a clinical and procedural basis. Psychology has advanced tremendously in its understanding of trauma and treatment. Clinicians today have more detailed understanding of various problems and more helpful treatment methods at their disposal than ever before. It is important to note that the knowledge and expertise a caregiver can bring will definitely help in the healing process, and the more the better! Does this mean that caregivers with little or no training who have a passion for helping will not be effective? Certainly not. “Traumatized children need specialist care... Yet with all that, in the right contexts, inexperienced people can usefully serve among needy children” (Myers, 1998: 48). Loving compassion is the main ingredient for facilitating the healing process, not a Ph.D. The knowledge of caring for people with emotional needs is an ongoing learning process in which all caregivers must participate.

Beyond the clinical side of understanding and working with psychological trauma, as Christians we believe that ministering to the hurting is more than a diagnosis and recovery process. Christ’s example shows how He provided the hurting with the care and compassion they needed, but also the spiritual food that would sustain them past the moment. Our work as caregivers should mimic Christ’s example. Our work to heal emotional and psychological wounds must be integrated into the reality of the complete healing that comes in the fullness of Christ’s love for creation.

When the knowledge and skills of psychological methodology are combined with the reality of Christ’s love and sacrifice, true healing can happen. Unfortunately too many caregivers have been restricted in helping others by relying too heavily on one aspect or the other. If we approach those in need with strictly psychological methodology and grief processing tactics we can help to some degree. The critical knowledge of the effects of trauma and grief are vital to the healing process but do not address issues of forgiveness and comfort in the face of tragedy. On the other hand, if we seek to help the hurting by claiming, “Just believe in Jesus and everything will be better,” we are looking past the

reality of loss and trauma. It is unquestionably true that the Holy Spirit will sustain and comfort us during pain and trials, but it is unfaithful to only focus on praying a “deliverance prayer.” Emotional wounds need care just like a cut on our leg. If we neglect the steps for proper healing we are not only deepening the injury, but failing to show how our relationship with Christ encompasses all of life – even the ugly parts!

Trauma and Children

The Value of Children

Children are naturally small and dependent for many of their needs. Their lives are usually directed by someone else. Almost every people group in the world regards childhood as a stage in life that comes to an end at some predetermined cultural or societal benchmark. Children and childhood can be defined in many ways highlighting physical, mental, spiritual, or emotional factors. These realities help us define childhood, but be very careful that they do not unconsciously facilitate a perspective of children which quantifies value in relation to developmental ‘stage’.

When we have the privilege to serve children in the name of Christ we will be confronted with the most discouraging and encouraging work imaginable. As we acknowledge the unimaginable effect that a crisis has had on a child, do not forget that God is sovereign and our responsibility is to serve those in need just as Christ served us. Children are the hope for the future. Children are created in the image of the Almighty God. Christ came for the children and widows. Commenting on the importance of children, Patrick McDonald remarks, “Scripture warns against seeing children as insignificant. God’s perspective is the opposite of the worldly mindset which tends to regard children as less important than adults and therefore low on the priority list” (McDonald, 2000: 39). In fact, if we look in the Gospel of Matthew Christ clearly states his value of children, “Take care that you do not despise one of these little ones; for, I tell you, in heaven their angels continually see the face of my Father in heaven” (Matt. 18:10).

We must never relegate children as less important members of society or undeserving of the same care we would give to more vocal adults. The world often finds it more convenient to ignore the plight of children simply because they have no formal societal voice. It is important to be aware of this common misperception because if we are not working vigilantly against it, there is a possibility for an unconscious distortion of how we value and interact with children. If our hearts are genuinely seeking a walk with Christ that honors all of creation and desires to show the reality of the Good News to the lost and hurting then we must recognize our position as caretakers responsible to the entirety of creation. It is our duty to respond to the needs of children just as God has responded to us. We are not afforded the option of choosing to deny help and care to children who

are in need. As followers of Christ we *must* respond to children in need; it is just that simple!

The Great Need and the Problem of Suffering

The Oxford Statement on Children at Risk frighteningly outlines the following crises currently affecting children:

- There are at least 100,000,000 children who live or work on the streets of our cities [UNICEF, 1994]. Most of these children are confronting the dangers of life in this hostile environment as a result of family breakdown.
- There are at least 10,000,000 children currently suffering the oppression of forced prostitution and another 1,000,000 join this industry every year [World Vision, UNICEF].
- During the period 1984 to 1994, more than 1,500,000 children were killed in wars, over 4,000,000 were disabled, maimed, blinded or brain damaged by wars and 12,000,000 lost their homes as the result of war. During this period, 35 nations are known to have conscripted children into their armed forces [Save the Children, 1994].
- Between 100 and 200,000,000 children are currently involved in child labour [UN Children's Fund]

(Oxford Statement on Children at Risk, 1997: Section 1).

These alarming statistics may seem too overwhelming to comprehend, or even too great to be able to change. As we are faced with what looks like an impossible task, remember that Christ calls us to be diligent and faithful in our work but leave the results up to him. Our work with children in need of emotional and mental healing must be kept in perspective to complete healing coming *only* through Christ.

Because we are human, as we work with children who are suffering it is natural to desire the total eradication of their pain. As followers of Christ and servants who go forward acknowledging the need for God's grace in our own lives, we cannot expect to personally be able to *solve* all of the children's problems. Our responsibility is to be faithful to the call God has placed on our lives to serve children. When we are faithful in service God is faithful in using our service.

Witnessing children suffering is not something that we will ever get 'used to.' Furthermore, we must recognize our own inability to provide the kind of complete redemptive good that comes only through Christ. The tension to want to be able to end suffering but recognizing the enormity of the task will often be a very discouraging reality.

As we work with children who have suffered the wounds of trauma be encouraged that amid what can look like a hopeless situation, Christ is at work and using his faithful servants. Our job is simple: trust God, and be faithful to his call.

Developmental Issues

Before we begin to interact and help children who are hurting, we need to understand some common characteristics. **Trauma affects children differently than adults.** A child's understanding of the world is not an adult's understanding of the world. "Children are likely to experience at least as much trauma as adults and probably more, because of their dependency and limited understanding" (Ochberg, 1988: 210). The most easily recognizable trait of the unique world of children is their dependence on others for so many things. For most children, a traumatic event will be rooted in the disruption of their dependence.

In addition to a child's situation of dependency, their cognitive development will drastically affect how they process a traumatic event. For young children, egocentrism is the most important characteristic. Defined by Piaget, egocentrism is the cognitive state of seeing the world only from your own point of view, without awareness that you are looking *only* from *your* own viewpoint. A young child may often believe that everything in the world is directly oriented around him/her. As a result of this, children may confuse traumatic events as consequences of their actions or behavior.

When we are interacting with children who have suffered psychological and/or emotional trauma, it is important to remember that their perspective on the cause of the trauma might differ from our own. Children often focus on reward or punishment as the measure for their actions rather than intent. For example, an earthquake where some family members die but the child survives may be interpreted as a punishment for something the child did, with his/her punishment to follow likewise. The perception that bad events are a result of needed punishment can be very confusing and damaging. Therefore, we must be aware of how a child's cognitive development may be a factor in our work to facilitate healing.

Children process trauma differently than adults, but not because they lack intelligence. When working with a child exposed to trauma, be aware that their intelligence and insight is just as perceptive (if not more perceptive) than your own.

Characteristics of Trauma

When working with children who have been exposed to traumatic events it is necessary to assess to some degree the severity of the traumatization. Traumatization and PTSD are unique because they result from one or more events which have happened either once or repetitively. Children who have been traumatized often feel "stuck" in the time period of

the trauma, and find it difficult or impossible to recognize life outside the traumatic event. In severe cases, children will often lose a sense of personal identity and only see themselves as the sum of their trauma. Characteristics of traumatized children will vary from child to child, but there are some signature behavioral symptoms that are easily identifiable. Flashbacks, hyperactivity, dissociation, hyper-vigilance, increased startle response, avoidance of intimacy, increased irritability, unwarranted feelings of guilt, and heightened anxiety are all marks of some traumatic event. The Diagnostic and Statistical Manual of Mental Disorders IV defines a more comprehensive description of traumatization under the heading of Post-Traumatic Stress Disorder, or PTSD:

A. The person has been exposed to a traumatic event in which both of the following were present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
- (2) the person's responses involved intense fears, helplessness, or horror.

B. The traumatic event is persistently re-experienced in at least one (or more) of the following ways:

- (1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed).
- (2) recurrent distressing dreams of the event (in children there may be frightening dreams without recognizable content).
- (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, even those that occur upon awakening or when intoxicated) In young children, trauma-specific reenactment may occur.
- (4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event (including anniversaries of the trauma).

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

- (1) efforts to avoid thoughts or feelings associated with the trauma.

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

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

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hyper-vigilance
- (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D is more than one month).

F. The disturbance causes clinically significant distresses or impairment in social, occupational, or other important areas of functioning (DSM-IV, 1994).

In addition to the DSM-IV classification of PTSD, other symptoms that may be present and often coexist are listed by Ochberg:

1. **Shame:** deep embarrassment, often characterized as humiliation or mortification.
2. **Self-Blame:** exaggerated feelings of responsibility for the traumatic event, with guilt and remorse, despite obvious evidence of innocence.

3. **Subjugation:** feeling belittled, dehumanized, lowered in dominance, powerless, as a direct result of the trauma.
4. **Morbid Hatred:** obsessions of vengeance and preoccupation with hurting or humiliating the perpetrator, with or without outbursts of anger or rage.
5. **Paradoxical Gratitude:** positive feelings toward the victimizer ranging from compassion to romantic love, including attachment but not necessarily identification. The feelings are usually experienced as ironic but profound gratitude for the gift of life from one who has demonstrated the will to kill. (Also known as pathological transference and “Stockholm syndrome.”)
6. **Defilement:** feeling dirty, disgusted, disgusting, tainted, “like spoiled goods,” and in extreme cases, rotten and evil.
7. **Sexual Inhibition:** in adolescents: loss of libido, reduced capacity for intimacy, more frequently associated with sexual assault.
8. **Resignation:** a state of broken will or despair, often associated with repetitive victimization or prolonged exploitation, with markedly diminished interest in past or future.
9. **Second Injury or Second Wound:** revictimization through participation in the criminal justice, health, mental health, and other systems.
10. **Socioeconomic Status Downward Drift:** reduction of opportunity or life-style, and increased risk of repeat criminal victimization due to psychological, social, and vocational impairment (Ochberg: 205, 208).

Issues of Trust and Safety

Children are very vulnerable to trauma because they are usually dependant on adults to provide safety and protection. **However severe the traumatization, the most universally significant effects are the loss of a sense of safety and the inability to trust others.** When trust is gone, a child’s world is a threatening and dangerous place. The sudden intrusion of a horrifying and destructive event is too much to comprehend. No one can be trusted to ensure safety, and finding a safe place seems impossible. The world has seemingly been shattered. A child who feels there is no safety or security will have a difficult time establishing an honest and intimate relationship with a caregiver. Children may even test the quality and durability of a relationship with a caregiver by exhibiting false emotions and then observing the caregiver’s reaction. Almost every action and reaction of a traumatized child will be affected by the child’s lost sense of safety. Because of the traumatic event, a child may feel that relationships cannot be trusted and safety is an illusion. As people who intend to provide care for children living with trauma, our primary task is to build, maintain and ensure a safe and secure relationship with the child.

Defense Mechanisms

Children who have been traumatized will often employ defense or coping mechanisms to help restore a sense of control to their life. Defense mechanisms are unhealthy tools for survival which are constructed in order to prevent from being overwhelmed by the full effect of the trauma. **As a counselor we must be ready to identify these coping, or defense mechanisms, and more importantly help the child move past them and begin healing.** Ochberg identifies these common defense mechanisms:

- (1) Denial: The most common. Creating an altered view of reality to make the situation more acceptable. A child may believe their own distortion of reality.
- (2) Repression: The “pushing under” of unwanted feelings, thoughts, or memories. Emotions and thoughts relating to the trauma are not allowed to be manifested. A good way to think of repression is like a ball being forcibly pushed under water. The more it is pushed under water, the more the ball will resist and try to come to the surface.
- (3) Projection and Displacement: Unwanted effects are irrationally attributed to someone or something else. For example, a child who has a violent outburst explains that it was caused by the presence of the family pet.
- (4) Fixation: Usually exhibited by severely traumatized children. Behavior that resembles an earlier age in life -- more specifically, behavior that resembles the age of the child around the time of the trauma (Ochberg: 199).

The adolescent child can exhibit all of these defense mechanisms as well as more adult-oriented intellectualization methods of coping with trauma. With adolescents there is generally more distancing and dissociation which is characterized by non-participatory behavior. When working with more mature children and adolescents, the benefit to the caregiver is the increased ability for dialogue.

Behavior and Assumptions

Many of the symptoms a child may exhibit which have resulted from trauma can be incorrectly viewed as behavioral problems. Children exhibiting symptoms of trauma or incorporating defense mechanisms may be judged as disrespectful, oppositional, un-loving, or troublemakers. Some symptoms that are even more confusing are laziness, apathy, or general disinterest. **Because the behavior or appearance of a child may disguise the deeper issue, the caregiver must remain vigilant and involved in order learn the true extent of the traumatization.** Keep in mind that each child is unique and will be affected by trauma in a unique way. Although multiple survivors of the same traumatic incident may exist, each will process, cope with, and heal the trauma in a personal and unique way. Do not make the mistake of assuming knowledge of how trauma has affected an individual.

The Stigma of Trauma

The words trauma, traumatized, survivor, etc., are often very offensive in a society. **In many cultures and societies, admitting emotional damage is a sign of weakness and inferiority.** Being identified as “traumatized” and then relegated among those who are “not able to cope,” is a strong deterrent for many people to take the necessary steps to healing. Children are especially susceptible to the negative social impact of exposing a traumatic event because of peer backlash. As counselors, we need to be sensitive to the existence of these stigmas and work especially hard to convey a sense of non-judgmental acceptance. In our work to establish trust and convey safety, it is very important not to push the child beyond what he/she is comfortable with sharing. Our role as a facilitator is made credible when we do everything possible to exhibit love and acceptance.

Issues of Re-traumatization

While working with children, we must proceed at the pace that they are capable of handling. We need to move forward in the healing process when they are ready and be patient when it is difficult for them. **The child will talk about his/her trauma when he/she is ready.** Forcing for catharsis is a very serious mistake many counselors may make out of inexperience. While it is important to keep the session moving forward, and helpful to emphasize that the child is no longer “stuck”, if we push too hard, the child will usually shut down. Generally, the counselor should sensitively monitor the progression of the interaction, and the willingness of the child. Once we are assisting the child in re-processing the trauma, it is necessary to make sure the process does not become too overwhelming for the child. If the session does appear to be too much for the child to handle, our responsibility is to bring the child back to the present and take a break. Gentle questions like, “Is it OK to be here?” and, “Is this too hard for you?” will make a quick assessment of the situation possible. **It usually takes longer than we expect for the child to begin to open up.** If we try to speed up the process beyond what the child is capable of, we greatly risk re-traumatization and the potential for causing greater damage. A child who has been hurt in the process of therapy will be even farther from the help he/she so desperately needs.

Re-traumatization is not limited only to the child. A child’s trauma can resemble a trauma we have experienced. At times it may be uncomfortable for us to hear the various stories of trauma, and we may feel overwhelmed. **If we are unable to engage the child in processing his/her trauma because of our similar experience, we may be sending messages that make the child feel it is *not* OK to be honest.** Our discomfort can convey a feeling of distance or anxiety that will damage the counseling procedure. We must be an unwavering guide and steady support, continually engaged with the child and involved with their story. If we are unable to provide the support they need because of our similar experience, steps should be taken to ensure the health of both counselor and child.

Confidentiality

Another aspect integral to the counseling process is the issue of confidentiality. **We have a responsibility to keep all that is said and discussed confidential!** If we casually disclose the private and sensitive information a child has been trusting enough to share with us, irreparable damage can be done. A trusting relationship means that there is no fear of talking about sensitive issues because they do not go beyond the counseling setting. When we work to establish a trustworthy counseling session, confidentiality is one of the primary foundations. Stating that everyone is responsible to each other within the group, and that confidentiality is necessary for the group to work well should preface work in the group setting. While the integrity of a group setting with children can often lose some of the strict confidentiality required for effective restorative work, taking definitive steps to emphasize the need for confidentiality will always be helpful. If the children understand that what is discussed is between them and you, gossip is less likely to happen. In the individual counseling setting, the responsibility for confidentiality is more clearly visible. The only time confidential issues should be discussed is within the further confidential circle of counselors for the specific purpose of broader insights and help for the child, or if the child has specifically mentioned something that jeopardizes the safety of the child another person. Various cultures approach the subject of confidentiality in numerous ways – if you are working cross-culturally be sensitive to the cultural standard.

Method

Role of the Counselor

Trauma shatters trust in relationships and any hope for safety. It can make a child feel so lost and afraid they do not know where to turn. **Your presence as a steady, caring, encouraging, loving, and non-judgmental facilitator is the best thing you have to offer.** In countless testimonials the counselor's presence was the most encouraging aspect of the therapy. The role of the counselor is to come along-side the hurting and help them stand. **The quality of your presence matters more than what you say.** Everyone from children to adults can sense if someone is actually interested in what they are saying. A traumatized person will not disclose deep, hurting issues if they feel the counselor is not interested in what they say. Ironically, some counselors try to combat this problem by energetically giving advice. This can be equally detrimental to the healing process.

Advice is almost always perceived as judgment. When we verbally judge or critique a hurting person, they are not encouraged to continue to be vulnerable and honest about their needs and hurts. Why should a person be honest about their trauma if they are just

going to get it thrown back in their face? **The main activity for the counselor is to be a listener, NOT to give advice.** Danielle Speakman comments, “Becoming a transformed person requires a heart that is willing to listen. Really listen. Be quiet again, and hear what the children are saying to you. Be quiet, and hear what God wants of you. Be still, and know that He is God...” (Speakmann, 2002: 146).

It is interesting to note that in some languages the word for “counselor” is identical to the word for “advisor.” Here again there are cultural differences which may affect the role of the counselor. The goal is to remember that our job is a listener. After all, if we do the majority of the talking, how will we ever know the needs of the hurting child? “LISTENING to children is important because they are made in the image of God and have inherent worth. This means that they are as important as anybody else is and that what they say needs to be given due weight...” (Miles, 2003: 62). Our posture and presence in our interactions with children should be primarily accompanied by questions that draw out and encourage the children to tell their story. If we want to convey trust in the relationships we are attempting to build with children we must provide them with the space to communicate freely.

Tools for Caregivers

As compassionate caregivers, we have a unique opportunity to express Christ’s love to hurting children. Trauma leaves both visible and invisible scars. The important job we have as counselors is to tend to the visible scars, and compassionately support the healing process for the internal scars. There are many techniques and tools available to help hurting children, and the ones included here are by no means exhaustive. You might find that some will work better in your situation than others.

Beverly James has compiled a helpful list of guidelines that should be kept in mind while working with each and every child:

Maxims

1. It is important to teach the child that part of the work of healing is to accept the past, not hide from it.
2. Invite expressions of experience through sound, movement, visual art, smell, taste, drama, song, and language. Exercise *all* the senses.
3. Don’t be overly impressed or frightened by emotional displays.
4. Demonstrate and teach the ideas that we each have the right to feel and say how we feel, that feelings are natural and we shouldn’t put them down.
5. Establish family traditions and rituals.
6. Speak of the future.

Myths

1. All they really need is love. (They also need limits, guidance, courage, time to heal and to accept the realities of their experience, and an enormous amount of the caregivers' patience.)
2. They will appreciate what you are doing and will show it. (Children often react negatively to positive counseling. The experience may generate great anxiety in children simply because that style of interaction is unfamiliar.)
3. Children's traumatic histories will fade in memory if they are allowed to forget them. (Children do not just forget pain and terror. They may hide from their memories, but their behavior is often directed by unexpressed feelings. Ignoring what is known to be true about the child can lead the child to believe that his past is shameful or too overwhelming for even adults to mention.)
4. You will like them. (Not always.)
5. You will be rewarded. (Well, maybe...someday.)

Messages Children Need to Hear

You are likable.
 You cannot overwhelm me.
 Others have been there too.
 There is hope.
 You have choices.
 You are needed.
 You make a difference.
 This is a safe place.
 It is not your fault.
 You are not a bad person.
 (James, 1994: 199-200).

The progression of the therapeutic encounter must follow a plan, and must offer hope for the future. A brief but helpful six-step guide to the initial healing process is outlined in *Disaster Mental Health Services, A Guidebook for Clinicians and Administrators*:

1. Make Contact: Begin with informal socializing, e.g., "It sure is hot today isn't it?" "How are you enjoying the games?" Avoid statements that might appear to be condescending or trivializing, e.g., "Everyone here is lucky to be alive." Do not begin by asking for a detailed account of the survivor's disaster experience.

2. Make Assessment: Evaluate and assess the individual's ability and willingness to shift from the present moment to a conversation about the traumatic incident. Follow the 'flow' of the individual's thoughts. During the course of the conversation, evaluate

how the person responds to an inquiry about where they were, or whom they were with when the event occurred.

3. Gather Facts: The gathering of facts is important because it is an efficient means to quickly determine who may be at risk due to exposure to life threat, grotesque experiences, or other traumatic stimuli. Describing facts is also easier for survivors than relating associated thoughts or feelings:

Helpful Questions:

- “Where were you when it happened?”
- “What did you do first, then what did you do?”
- “What do you remember seeing, smelling, touching, tasting and hearing?”
- “Where is your family?”
- “Where were the other people?”
- “Is there anything anyone said to you that stands out in your memory?”
- “How has this experience affected your sleep, appetite, play-time?”

4. Inquire about Thoughts: Use the description of facts that the survivor has provided to generate questions about associated thoughts.

Helpful Questions:

- “What were your first thoughts when (the incident) happened?”
- “What ran through your mind when you first saw, smelled, touched, tasted, heard _____?”
- “What were you thinking as you _____?”
- “What do you think about, now that the immediate threat is over?”
- “What thoughts will you carry with you?”
- “Is there any particular thing you keep thinking about over and over again?”

5. Inquire about Feelings: Use the description of thoughts that survivors have provided to ask questions about their emotional experiences. Remember, this is a brief intervention and it precludes in depth exploration and ongoing support. Consequently you must use care in regard to any questions about feelings. It is important to avoid heightening a survivor’s sense of vulnerability to the degree that it causes overwhelming anxiety. Obviously, under such time constraints, assessing capacity to manage anxiety is difficult, so it is best to proceed conservatively, i.e., continually monitor the survivor’s reactions during the course of talking about feelings and reassess the need to refocus the survivor’s attention on the present and action-oriented steps to solve problems. If the survivor is able to tolerate talking about feelings, look for opportunities to validate common emotional reactions and concerns. ‘De-pathologize’ survivor’s reactions, that is, inform them about normal reactions to the ‘abnormal’ event to provide reassurance. Helping survivors to understand the common course of traumatic reactions, while giving them an opportunity to discuss trauma-related thoughts and feelings will give the survivor

a greater sense of control and prevent the adverse effects of re-traumatization or dissociation.

Helpful Questions:

“What was the most difficult or hardest thing about the event for you?”

“What did you feel when _____?”

“How have you been feeling since _____ happened?”

“How are you feeling now?”

6. Support, Reassure, Teach: Though listed as the last of the six steps, offering support, reassurance, and providing information should actually take place throughout the entire process. Providing support by reflective listening, a willingness to compassionately care, and helping to educate about the common characteristics of trauma will help the survivor cope with the traumatic event. Reassurance about the normal reactions to trauma will usually help the survivor understand and cope with the presence of self-criticism, anxiety, worry, helplessness, or loss-of-control.

Helpful Questions:

“What has helped you to cope with this experience?”

“Who, if anyone, do you talk to?”

“What seems to help you get through the particularly difficult times?”

(Young, et al., 1998: 40-42).

Techniques

“The fundamental stages of recovery are establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community” (Herman, 1997: 3). Because every survivor of trauma needs to tell his or her story to begin healing, the more effectively we can draw out that story the better! Some communication techniques that are *very effective* to the discussion process are:

1. **Silence** - avoid interruption, allow the child time, and facilitate uninterrupted catharsis
2. **Restatement** - check and clarify terms and listening accuracy
3. **Paraphrasing** - summarize main points of conversation
4. **Reflection of Emotion** - mirror and acknowledge emotional reactions
5. **Open-ended Questions** - what, why, how, describe, tell me...
6. **Nonverbal Communication** - attentive body language conveying your continued interest and concern

Behavior and responses that are *bad* for the discussion and *do not* facilitate a helpful interaction are:

1. Ordering or Commanding - e.g., “You have to be happy now...” Produces fear and resistance.
2. Threatening or Warning - e.g., “You’d better stop acting this way...” The child will no longer trust you to share his feelings.
3. Preaching or Moralizing - e.g., “If you were closer to Jesus, you would know how to get through this...” Sends the message that the child is “bad.”
4. Advising and Giving Solutions - e.g., “All you need to do to feel better is...” Our job is not to solve the trauma for them. We do not have their solution.
5. Trying to Persuade or Argue - e.g., “Don’t you think this would help...?” It is unhealthy to push the child faster than he can heal.
6. Judging/Criticizing/Blaming - e.g., “You are not thinking clearly...” Pronouncing a judgment belittles the already traumatized child.
7. Praising or Agreement - e.g., “You are so cheerful after what you have been through, I think you’re OK.” This shuts down the conversation.
8. Ridicule or Name-Calling - e.g., “You were so frightened that you wet yourself?!” The damage this can cause, can seriously hurt a child.
9. Analyzing or Diagnosing - e.g., “Your problem is...” We must facilitate a continued dialogue, not a short and incomplete dialogue.
10. Sympathizing or Reassuring - e.g., “You will be just fine, I know what you have been through.” Let them tell *their* story, not listen to yours.
11. Probing or Questioning - e.g., “Why didn’t you...,” or “What in the world did you think was going to happen?” Questions should open up possibilities for more discussion, not imply guilt or blame.
12. Sarcasm or Diversion - e.g., “Wow, that traumatic event sure could ruin my day!” The focus is always on the child and their experiences, not the counselor.
13. Silence/Distance - Your body language is very important throughout the session. If you appear that you don’t care about what is being discussed, the child will not want to continue.

The intervention of the caregiver is most effective when it is kept simple! Be encouraging! We may know the provision of the Lord will strengthen us through difficult times and feel the need to singularly rely on this type of encouragement, but for the traumatized child this can seem impossible to comprehend. The way to communicate the reality of Christ’s unfailing steadfast love is through the way in which we value and listen to each child we have the privilege to serve. “‘For I know the plans I have for you,’ says the Lord. ‘They are plans for good and not for disaster, to give you a future and a hope’” (Jer. 29:11). We can do so much to re-vitalize a child’s life through our care and concern, fueled by the reality of Jesus Christ’s world-changing love. **We do not serve children to**

simply give an answer to their pain or provide a quick solution. Our job is to show Christ's love through patient, supportive, listening and care.

Trust the Process

As we encourage each child, we may feel as if we are not moving forward, or that we are not “doing” enough. **Be patient!** Sometimes we will feel like we are just wasting time that could be better spent in an activity or discussion. Let each child heal at his own pace. Time builds trust and acceptance, which are the most valuable foundations of any healing relationship. We always want to invite children to participate, but we cannot force them to begin healing. Continual assurance of a safe and trusting relationship while encouraging each child is the most basic and helpful thing we can do. It is this prayerful, Christ-like care and sensitivity throughout our entire interaction that will have the greatest effect. Some children will eagerly participate in every activity, while others may seem distant or distracted. Trust the process, and do not become sidetracked with positive or negative judgments about your personal effectiveness. As many Christian leaders have said, “Go in the power of the Spirit, and leave the results to God!”

“So often we are influenced by the sense of achievement, power and pride that comes from our positions, our posts, our potential, our perceived power, the ability to change a child’s life, the ability to open a child up emotionally, the ability to lead an organization, to feed five thousand. But such gifts become clanging symbols. Worse, they become vessels for Satan to change what God meant for good and twist it to be an evil charade of its God-given and Godpurposed commission. We need to be willing to take up the challenge to let go to God’s will...” (Miles: 221).

Group Counseling

Group counseling is best described as a guided discussion moving toward healing and empowerment. The dialogue that will naturally occur within the group should always be directed back at the children for continued discussion. The counselor’s main function is to keep the children talking and engaged with whatever is being said. Simple questions like: “What do you think about that?”, and “How does that make you feel?” will validate responses and encourage further comments. Damon Mandell et al., have provided a helpful list of objectives for group work:

1. Define acceptable behavior of group members and introduce a respect for boundaries.
2. Promote group interaction and reinforce cooperative efforts.

3. Introduce and encourage the discussion of common experiences to reinforce a feeling of togetherness and promote group cohesion for both children and caregivers.
4. Improve self-esteem through validation of individual feelings and ideas, acknowledging each member's importance in contributing to the group experience.
5. Help group members to understand the purpose of the group.
6. Enhance caregivers' capacity to begin to view their children with increased sensitivity, understanding and empathy (Mandell, et al., 1990: 27).

Techniques that work well when facilitating a group discussion will build a trusting relationship with each child, rather than a dominant or distant role of authority. A simple method to help keep a child talking is to parrot back what he has just said. When we rephrase the content of what a child is talking about instead of giving an opinion or critique, we are encouraging the child to continue talking. Parroting shows the child that you are listening and not out to correct them. For many children, this approach will be confusing and they will have difficulty continuing. Children are used to being told things, they are not used to talking about what *they* think and feel. In the group setting it is important for each child to know he can say anything he wants to because the integrity of the group will not be damaged. This should be communicated at the very first group session.

The only time a counselor should intervene with authority into what a child is saying is if it is obviously abusive to another child. Even this type of moment can be explored for group discussion. The counselor can encourage the child who has just been slandered to express how he feels after hearing the negative comments, and then explore the reasons for the abusive child's actions. This is a practical application of group dynamics, and is excellent discussion material.

Individual Counseling

When we counsel a child individually, the dynamics of the situation are much different from the group setting. The first unique aspect of one-on-one counseling is the inherent closeness and intimacy. This reality can make it difficult for some children because they feel less secure without any peers. That is why the first task we must address is establishing a trusting relationship with the child. Some children will feel "cornered" and will not be receptive to the session. Depending on the nature of a child's traumatic experience, it may be prudent to involve another caregiver in order to assure safety. Other children may jump at the opportunity to finally have their words heard. We must treat children uniquely and be sensitive to their comfort or discomfort in the session. Everything we do and say to a child in the individual session sends a message. We always want to send the message, "You are OK, and I am not here to judge you." **Look into the**

child's eyes. Show interest in them and concern for anything that might be troubling them.

During an individual session you will have more time for the child to go into the details of his/her story and therefore more possibility for discussion. Your presence as a steady guide through the frightening experience of the trauma will be more needed than in the group session. Remember to communicate your concern and stability through all your actions and words. One of the most common mistakes many counselors make in individual sessions (and often in group sessions) is to speak too much, or respond too quickly. Take your time, and do not rush the natural process of letting the child reveal the trauma as he/she is ready. You may feel that if there is not an abundance of time with the child, something meaningful must happen as soon as possible. Only the traumatized child, and not the expertise of the counselor or the amount of time control the cathartic venting of traumatic experiences in the session. We must build a trusting relationship with the child, and initially just open up a dialogue about the *facts*. As we maintain our presence and clarify facts, the feelings will start to come out. Do not push the child; take what he/she has given you and gently ask questions.

The time we have and the circumstances of the situation will play a large role in how much can be accomplished. Try to find a space free from distractions that would impair the effectiveness of the session. Taking a child aside for an "individual" session while he can still see his friends playing games or enjoying each other's company is not going to be very productive. Be realistic about what can be accomplished, and let the child indicate when he/she wants to open up.

Play and Art Therapy

The first step of any healing process is to establish a method of communication. We must interact in a way in which the child feels comfortable to express the trials of his/her world. Play and art therapy as a method for helping hurting children is one of the most effective methods to facilitate healing. Playing is natural for children and provides a known and comfortable environment in which to interact. **Play therapy is the use of play to help work through the traumatic event, by re-creating, assimilating, and healing negative thoughts and feelings associated with the trauma.** The free and uninhibited expression of thoughts and emotions during play can be a great benefit to the therapeutic process. A traumatic story that can be too difficult to describe in words is often easily conveyed through play. Playing gives the child a familiar place to have fun and be a kid!

Children can have a difficult time talking about their thoughts and feelings. When we play a game or involve the child in some creative artistic process, there are many ways to begin a conversation. **Using the natural situations that arise from games and play, we can begin a healing dialogue.** A good example of an artistic exercise that holds inherent

discussion possibilities, is where the child is instructed to draw an outline of his head, and then fill the inside of the 'head' with drawings showing his thoughts. When the drawing is finished, the counselor can immediately begin to ask questions about the pictures and start the counseling process. "If the artwork is representational but the content is still not clear to the therapist, it is safest to be open about that and to ask for clarification. To guess incorrectly can be distressing to (the child)" (Rubin, 1984: 121). In more physically active games like capture the flag, a helpful question might be, "What happened to you when you were captured by the other team?" While working with each child, remember that we are always looking for the deeper issue. Provide a door for the child to open into deeper subjects if he/she wants to. We are not going for questions that only draw out yes or no answers. Help the child begin talking by asking open-ended questions that require some discussion.

It is very important to note here that play and art therapy works so well because of its intrinsic boundaries. Boundaries equal safety. **Remember that in everything we do, we are trying to convey safety and security.** Games, art, and play are a safe world because they exist outside of "reality." We must preserve the world in which these fun activities exist. If the safe environment of playing games or creating art is warped, the quality of effective communication will be reduced. We must clearly establish the rules of each game and uphold fair and objective leadership throughout every activity.

When playing a game with any child, our objective is the relationship, not who has won or lost! In the same way, in any creative/artistic situation, the purpose is not good vs. bad art. "Remember that the end is not art, but therapy" (Rubin: 112). **In any activity, the goal is to draw out the child and make him/her feel comfortable to talk about his/her feelings and thoughts.** Everything within and around the play and art is potential discussion material with the child. Questions that explore feelings and thoughts can come naturally out of play, games, and art. It does not matter who won the game or whether the art of an individual child is "good" or not. Games and art are fun by themselves; we are just using them as a medium to start a discussion with the child.

When choosing games, some basic criteria are:

1. The game should be familiar, or easy to learn.
2. The game should be appropriate to the age/development of the participants.
3. Clear aspects of the game can be utilized in the therapeutic process.
4. Supervision and organization by counselors preserve the boundaries and safety of the game.

When choosing art activities, some basic criteria are:

1. Everyone can participate in the activity.
2. There are enough materials for all the participants.

3. Clear aspects of the art and/or artistic process can be topics for discussion.
4. The activity is enjoyable and fun.

When choosing music activities, some basic criteria are:

1. There is no pressure about playing music the “right” way.
2. Everyone can participate musically.
3. The counselor directs the tempo and mood of the music.
4. Sensitivity toward cultural music issues.

Preparation

In order to effectively run a program for children, several steps must be taken. The following list outlines some of the major issues for consideration *before* starting the camp.

1. Counselors: The program hinges on the relationship between the children and the counselors. Establish the qualifications necessary for counselors, and confirm the total number available. The number of counselors you have will directly effect how many children can attend.

2. Age and Number of Participants: If we are to meet the needs of children attending the camp, we have to know something about them. How many children are there? Establish the ratio of children to counselors that will work best for your purposes. Generally, around 8 children per counselor is the maximum number possible to maintain positive group interaction and adequate supervision. Proceed with whatever works for you, but keep in mind that with more children, there is more organization required. What is the age distribution of all the children? The age of the participants will dictate what types of activities will be needed, and how the content will be taught.

3. Location: Familiarize yourself with the area in which you will be running the camp. Safety is the most important aspect to consider. Security and the protection of the children from outside threats is vital. Choose a location for the camp that will not put the children in danger when traveling there. Consider the type of games and activities that can be done with the available space. Are there suitable playing areas? Are there alternative indoor or sheltered areas, and accessible toilet facilities? Will the children be fed on-site, or go home for lunch? Will the children be housed at the location, or travel back and forth from home? In addition to the counselors, is staff available to provide drinking water, prepare food, and clean facilities?

4. Supplies: Plan out the games and activities and consider all the materials you will need given the number of children who will be attending. Are you using balls, nets, cones, paint, paper, crayons, etc.? Are you designating teams with T-shirts, arm bands, etc.? Is there going to be a presentation at the conclusion of the camp where you will need some prizes or awards? It is always better to plan too many activities and end up with unused materials, than be unable to do activities because of not having materials.

Care Camp Elements

Games and Activities

Listed here are some games and activities that may be useful in working with children. You may find some will work better than others. Use your imagination to create new games that will meet the needs of the children in your area.

Teamwork Focus Games:

Human Knot:

Children in groups of about 5 stand in a circle and extend their hands into the circle. Reaching across the circle, each child takes the hand of two different children. When every hand has been clasped by another, the object of the game is to “untangle” the knot that has been formed without letting go of any hand. Allow enough time for the game to be played out and not left unfinished.

Stop the Leak:

Each team is given a bucket filled with water that they all must help carry a specified distance. The bucket will have 1 or more puncture holes in it than the total number of all the team member’s hands. The team who can retain the most amount of water in the bucket over the length of the course is the winner.

Get Up, Stand Up:

Children are paired off and instructed to sit down on the floor back-to-back. Then, without using their arms, they must stand up pushing off of each other. (This game can also be done as a speed competition between all the pairs of children.)

Scavenger Hunt:

Each team is given a list of objects they must collect in order to win. The team who completes the entire list first is the winning team. The more

creative you are in selecting which objects will be on the list, the more interesting the game will be. Anything from common items around the camp area, to hard-to-find items are acceptable. An important element to consider is whether you want the children to search for items outside of the camp area; this will depend on your location and the safety of the area. For a fun twist to the game make one of the items on the list a counselor with a unique talent.

Tire and Pole:

Each team is assembled around a vertical pole in the ground with a tire sitting around it. The object of the game is to lift the tire off of the pole. Because the pole will be taller than the children, they will have to creatively work together to lift the tire up and over it. The team completing the task first is the winner. (Close supervision is required in this game as there is the potential danger for children falling off each other's shoulders.)

Egg in the Middle:

Each team is given a large soda-pop bottle, 1 large rubber band, and 4 pieces of string. The soda-pop bottle is placed upright inside an approximately 3 foot wide circle drawn or traced on the floor. The object of the game is to use the string and rubber band to remove the bottle from the circle without knocking it over. Allow enough time for the children to try different ideas and methods for removing the bottle. Each team can try as often as they want to remove the bottle, and the first successful team is the winner. (One method that works particularly well is to tie the string sections to the rubber band equally far apart and pull simultaneously on each of them. This pulls open the rubber band to a larger size which can then be lowered over the bottle. When the tension on the strings is released, the rubber band will close around the bottle making it possible to lift it out of the circle.)

Spider Web:

Between two poles or trees, tie one string even with the ground, and another taller than the children. Between these parallel strings tie several vertical strings. Finally, tie some more strings between the vertical strings. When completed, the effect should resemble a large spider web. The object of the game is for each team to get through the web without touching any of the strings. The difficulty is that each "hole" can be used by only one team member. Some children must have their teammates lift them through the holes farther above the ground. This game can be played with or without a time limit. The team with the most number of children

who make it through the “web” without touching any of the strings is the winner.

Shoe Crazy:

All the teams are instructed to remove their shoes and stand side-by-side forming a large circle. Stack the shoes into a single large pile in the center of the circle of children. When the signal is given, each child must find his shoes and put them back on. The team who has all of their shoes on first is the winner.

Obstacle Course:

(There should be an equal number of children on each team for this game to work properly.) A course is established with as many different obstacles as there are children per team. The object of the game is for each team to complete the obstacles in succession, with a different child for each distinct obstacle. Teams must decide which team member is best suited to each challenge. The game will be more interesting if each challenge is only able to be completed by a small child, or a tall child, or a fast child, etc. The first team to complete the course is the winner

Large Games:

British Bulldog:

One child stands in the middle of the playing area and the rest of the children stand at one end. When the child in the middle yells “British”, the rest of the children must run to the other side without being tagged by the child in the middle. If a child is tagged, he joins the child in the middle and chases the other children trying to cross the playing area. This continues until all the children have been tagged.

Sharks and Minnows:

Similar to British Bulldog, this game is usually played in water, but can easily be played on land. A few children or leaders are designated “sharks”, and all the rest of the children are “minnows”. All the “minnows” stand against one end of the playing area and must cross to the other side without being tagged by the “sharks”. If a “minnow” is tagged he must sit out until the next game begins. This continues until there are no more “minnows” left.

Capture the Flag:

Divide the children into two large teams. A playing field is defined with equal amounts of space for each team’s territory. Each team is given a flag and instructed to place it somewhere in their territory. The object of the

game is for one team to take the flag from the opposing team, and return with it to the location of their own flag. Any time a child is in the opposing team's territory, he is susceptible to being tagged. Any time a child is holding the opposing team's flag, he is susceptible to be tagged. When a child is tagged, he is taken to "jail" where he must await the end of the game, or rescue by a teammate. A child in "jail" can be freed by a teammate who has not been tagged. If a child holding the opponent's flag is tagged, he must go to "jail", and surrender the flag. Children may pass the flag to each other at any time. The winner is the team who successfully brings the flag of the opposing team safely back to their own flag.

Dodge Ball:

Form a large circle of children. Select a few children to stand inside the circle. There are two or more medium sized balls (soccer, volleyball, etc.) that the children forming the circle will throw at those children in the middle. If a child in the middle is hit with the ball he is out until the next game begins. If a child in the middle can catch the ball being thrown at him, the child who threw the ball must exchange places and go into the middle of the circle. The game continues until there are no more children in the middle.

Pandemonium Dodge Ball:

Identical concept as regular dodge ball except the children are free to run around the entire playing area. To move with the ball, a child must hop on two feet or dribble the ball like a basketball. (To make the game more exciting, try adding several more balls.)

Tug-O-War:

Divide the children into two large teams. Each team is given the end of a long single, and sturdy rope. The team that can pull the rope a specified distance is the winner.

Freeze Tag:

Combine all the children into one group, and select a few children to be "it." The object of the game is for the children who are "it" to tag the other children. When a child is tagged, he must freeze in the spot he was tagged, however, he can move again if he is tagged by his own teammate. The game is over when the children who are "it" have "frozen" all of the other children. (Designate more children as "it", if the game does not appear to be challenging enough.)

Relay Races:

(All of the relay races are more effective if there are equal numbers of children per team)

Cup of Water:

Each child must run to a specified point and back with a cup of water.

The team who finishes first and has the most water in the cup at the end of the race is the winner.

3 Legged Race:

Children are paired together and have one leg tied to each other. Each pair of children must run to a specified point and back. The first team to have every pair of children complete the course is the winner.

Tennis Ball Dribble:

Each child must dribble a tennis ball (or other small ball) to a specified point and back. The first team to complete the course is the winner.

Egg n' Spoon:

Each child must use their mouth to carry an egg sitting in a spoon to a specified point and back. The first team to complete the course and not break the egg is the winner. (Children may not use their hands to catch the egg if it is falling from the spoon.)

Over and Under:

A medium sized ball (soccer, volleyball, etc.) must be passed from child to child, alternating over the head and under the legs. The ball starts with the first child in line, travels to the last child in line, and must return to the first child in line. The first team to complete the task is the winner. (This game requires an equal number of children per team.)

Wheelbarrow:

Children in pairs must travel to a specified point and back. One child holds the legs of the other, and the other child must use his hands to walk. The first team to have every pair complete the course is the winner.

Crab Walk:

“Walking” on both hands and feet with his stomach to the sky and back to the ground, each child must travel to a specified point and back. The first team to complete the course is the winner.

Trust Games:

Niagara Falls:

A child stands on a chair and folds his arms to his chest and closes his eyes. He must fall backwards into the waiting arms of several leaders. Each child in the camp should get a chance to participate in the activity. (It is absolutely crucial that the leaders responsible for catching the child are capable of carrying his weight and not dropping him!)

Blind Man's Walk:

Children are separated into pairs and given a blindfold. After one child is blindfolded and unable to see, his partner will lead him around the camp area. After a period of time they will exchange roles. The non-blindfolded child who is leading must point out obstacles and dangers.

Up in the Air:

Two leaders hold a sturdy board near the floor while a blindfolded child stands on top. The leaders slowly lift the board and try to confuse the child about the height above the ground. The child is told to jump off of the board when he feels that it is almost too high above the ground. (This activity usually works best as a demonstration for the entire camp or a large group of children. Also, be ready to steady the child, as they usually will be prone to falling.)

Sports Games:

Some effective sports games are Soccer, Volleyball, and Basketball. "The value of sports for a child's physical and mental development has long been acknowledged. And much has been written about the values and social skills that are learned through team sports, for example, conflict resolution, collaboration, understanding one's opponents and how to win and lose with respect for others" (UNICEF, 2002: 30).

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