



**STARTTS**

**Group Counselling Program for  
Traumatised Children**

**2001**



# The children – STARTTS clients

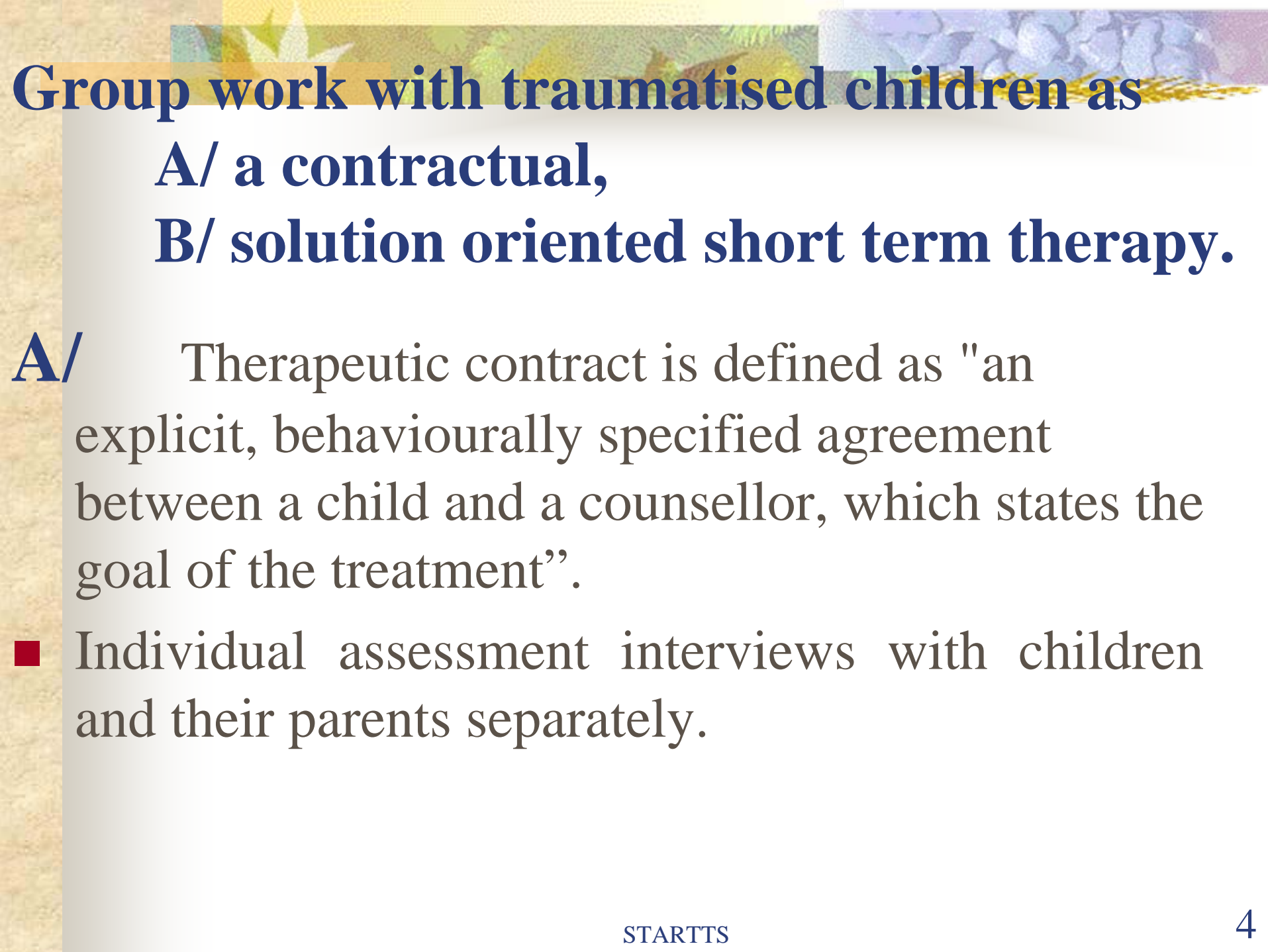
Most children who are STARTTS clients have suffered extensive trauma including:

- Witnessing horrific atrocities and destruction;
- Being exposed to shelling, starvation, lack of shelter and water;
- Direct death threats; Witnessing torture of their parents;
- Having to move from a place to place; Living in refugee camps.



# Traumatised Children

- A majority of the children experience Posttraumatic Stress Disorder symptoms such as:
- traumatic nightmares, night terrors, insomnia,
- irritability, withdrawal, difficulties with concentration and memory impacting on their school work,
- difficulties forming relationships with their peers, anxiety, and various fears (eg. fear of uniforms, fear of airplanes).
- Some children suffer from speech disorders such as selective mutism and stuttering.



# **Group work with traumatised children as** **A/ a contractual,** **B/ solution oriented short term therapy.**

**A/** Therapeutic contract is defined as "an explicit, behaviourally specified agreement between a child and a counsellor, which states the goal of the treatment".

- Individual assessment interviews with children and their parents separately.



## **A/ a contractual therapeutic approach**

- The interviews are semi-structured as that allow for a possibility of an extensive exploration and clarification of the child's problems and symptoms.
- Helping children to get a clear picture about desired changes on emotional, cognitive and behavioural levels, and to define and clarify what would be positive outcomes and goals of the treatment.

# Contract setting – 3 steps:

- At the beginning of the counselling process, some children are not able to define their problems, due to the complexity of PTSD, or a lack of understanding of their symptoms.
- 1** Preliminary phase (negotiating with the child) which includes psychoeducation on children's symptoms, and clarification of their difficulties.
  - 2** Listing and prioritisation of the symptoms and difficulties.
  - 3** Visualisation of desired outcomes. Children are suggested to “see the picture of a positive outcome of their problem” (including images, feelings, bodily sensations, sounds). It strengthens motivation and energy necessary for the healing process.



## **B/ Solution oriented short-term therapy**

Short-term intervention was selected as the preferred mode of intervention for a number of reasons:

- The rationale - change can occur quickly, therefore intervention should be as minimal as possible.
- Solution focused-talk instead of problem-talk. Consequently, instead of analysing the problem in details, a focus is transferred to seeking solutions.
- This approach is strength rather than deficit approach, as children are aware of what their problem is and they can access necessary resources to find solutions.

# Group structure and facilitating

- The group counselling program for traumatised children consists of eight 2-hour weekly sessions.
- There are usually 7-9 children in each group.
- Two group workers facilitate this group as:
  - Two languages were in use during the group work, thus one facilitator is more engaged in interpreting while the other is more engaged in facilitating the program.
  - One of the workers was always able to focus on observation of the process while the other worker facilitated the process.

# OUR EXPERIENCE

- **Group program for children aged 9-14.**
- So far we have organised two types of groups:
  - A/** Groups of children, from all ethnic backgrounds from the former Yu-countries, with two facilitators: English speaking art therapist and Bosnian/English speaking group counsellor,
  - B/** Groups of children from different countries (B&H, Croatia and Somali children) with two Bosnian/English speaking counsellors.
- Preconditions for organising groups of children from different national or ethnic backgrounds:
  - Group cohesion and sense of safety.
  - No more than two languages.

# Counselling stages

- The group program was based on the trauma recovery model proposed by Herman (1992). The first stage is **I/ safety building**, the second stage is **II/ exploration of trauma**, and the third stage is **III/ social reconnection**.

## STAGE I

- Consequently, the first sessions focused on establishing the feelings of safety and trust within the group, and developing a high level of group cohesion.
- Also, the participants' strengths were identified and reinforced.



## STAGE II

The succeeding sessions focused on the problem children identified in their individual contracts, and exploration of their links to the trauma experience.

■ The direction of the counselling:

from present symptoms → past trauma:

- **Starting from symptoms and orientation on the goals defined in the contract with every child, rather than starting from the trauma story.**
- **Opening traumatic experiences to the extent relevant for achieving particular therapeutic goals.**
- **Use the group dynamic to help each group member to achieve her/his therapeutic goals.**



# *Use of expressive techniques*

Various group techniques and interventions will be in use to achieve individual goals.

- Expressive techniques including:
  - **Clay, paint, collage, drawing** as a projection of inner condition;
  - **Sand-tray** – projection of process and the possibility of following it,) have been used as an independent method of intervention, and in combination with other therapeutic techniques, such as
  - **Role-playing**, or Gestalt techniques such as “**Double chair**”- inner dialogue, imagined dialogue with significant others etc., **Fishbowl** technique...



# The therapeutic value of expressive techniques

- it provides children with a universal medium for expression that is not solely dependent on language.
- helps to externalise the difficulty and can enable the child to safely give expression to their feelings, problems and memories often in symbolic forms.

# Obstacles to the recovery process

- Interventions on removing the obstacles to the recovery process are, also, the essential part of the counselling program at this stage.
- That includes interventions on:
  - **Dysfunctional beliefs**, coming from families or broader community, (eg. "I will never recover");
  - **Lack of basic safety** (Some parents or communities can not provide basic safety).
  - **Relationships** with other traumatised family members might lead to further problems for the child as she/he can not find adequate protection because the whole family is traumatised), etc.

# Interventions for these obstacles mainly consist of :

- Cognitive reframing and neutralisation of dysfunctional beliefs and replacing them with a new belief system
- Confrontation and Group discussion
- Additional treatments (e.g. family therapy) or interventions on a community level)



## **STAGE III**

### *The final stage of the treatment - Closure*

The final sessions focused on “here and now”:

- Consolidation of the achieved goals – emphasis on solutions
- Work on social relationships – peers, siblings, parents, and on future plans and goals
- Ethical considerations e.g. revenge/forgiving vs. seeking social justice

# Evaluation

- Evaluation-carried out 2 months after the group program.
- The basic aim of the evaluation is to assess if a therapeutic contract with the each child has been achieved. Evaluation is organised through semi-structured interview with each child / parent separately.
- With the contractual therapeutic approach evaluating the group program is relatively a simple and clear process.
- In case that the therapeutic goals have not been achieved, or have been only partially achieved, further interventions are planed with children and parents.