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:

1. 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.

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.
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.
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 planned with children and parents.